

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
05716					CERTIFICATE OF DEATH					05711					
1. DECEASED-NAME (Type or print) First Middle Last LEWIS Clifford. RENSCHAW					2a. DATE OF DEATH Month Day Year APRIL 3 1969					2b. HOUR 2:15 PM					
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 12-1-99			6. AGE (In years last birthday) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Painter			12b. KIND OF BUSINESS OR INDUSTRY ***						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9946 MAYFIELD DR.					
14. FATHER'S NAME First Middle Last JOHN W. RENSCHAW					15. MOTHER'S MAIDEN NAME First Middle Last MARY K MOYER										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 214-14-4815			17. INFORMANT MISS MAMIE RENSCHAW			Address as above.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 592X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral chronic pyelonephritis</u> (c) <u>Bilateral ureteral obstruction by calculi</u> several years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 1950's to 4-3-69, that (I) (we) last saw the deceased alive on 4-3-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE George A. Gray, Jr. MD			22c. DATE SIGNED 4-3-69			22d. PHYSICIAN'S NAME (Type or print) George A. Gray, Jr. MD			22e. ADDRESS 474 Cherry Chase Drive Cherry Chase, Md. 20015			22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-7-69		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville, Montg. Co. Md.							
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland			25a. REC'D BY REGISTRAR APR 7 1969			25b. REGISTRAR'S SIGNATURE Charles Judge									

05716

CENTRAL DE DEATH

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RECEIVED

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VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
05718 CERTIFICATE OF DEATH 05713																	
1. DECEASED-NAME (Type or print)			First Katherine			Middle P.			Last Reynolds			2a. DATE OF DEATH Month Day Year April 26 1969			2b. HOUR 10 19 A.M.		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 01-22-1893			6. AGE (In years last birthday) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Wash., D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.								
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auditor			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash., D.C.			13b. COUNTY Washington			13c. CITY OR TOWN Wash., D.C.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4550 Conn. Ave. N.W.					
14. FATHER'S NAME First Middle Last Oswald B. Parsons			15. MOTHER'S MAIDEN NAME First Middle Last May. Harbold M. Groves														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Address Mrs. Mae Harbold-117 Monticello Ave. Annapolis, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 203 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1967, to present, 1969, that (I) (we) last saw the deceased alive on April 25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Arthur J. Anderson M.D.			22c. DATE SIGNED April 26, 1969			22d. PHYSICIAN'S NAME (Type) Arthur J. Anderson											
22e. ADDRESS 916 19th Street N.W. Wash D.C.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/29/69			23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D. C.								
24. FUNERAL DIRECTOR The S. H. Hines Co			25a. REGISTERED BY REGISTRAR APR 30 1969			25b. REGISTRAR'S SIGNATURE Charles Judge											

MEDICAL CERTIFICATION

02718

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

TO: [Illegible]

FROM: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

APPROVED AND FORWARDED: [Illegible]
SPECIAL AGENT IN CHARGE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05719

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05714

1. DECEASED-NAME (Type or Print) <i>William F. Rhodes</i>			2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input checked="" type="checkbox"/> Year <i>4/16</i> 19 <i>69</i>			2b. HOUR <i>10:30</i> M			
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>11/25/18</i>	6. AGE (In years last birthday) <i>50</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>4</i> Day <i>16</i> Year <i>1969</i>			2d. HOUR <i>10:30</i> M
7a. BIRTHPLACE (State or foreign country) <i>Dist of Co. U.S.A.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Private</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>828-Bowie Rd.</i>	
14. FATHER'S NAME <i>William T. Rhodes</i>			15. MOTHER'S MAIDEN NAME <i>Louise Powell</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16b. SOCIAL SECURITY NO. (If you give war or dates of service) <i>Army 1941-1945</i>		17. INFORMANT <i>Majorie Rhodes</i>		ADDRESS <i>15 Above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute.</i> <i>4/23</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Arterio Sclerosis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i> <i>years</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>April 17/1969</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/19/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 Rockville Pike</i>				ADDRESS <i>Rockville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

02112

100-10-0203

John G. Hall

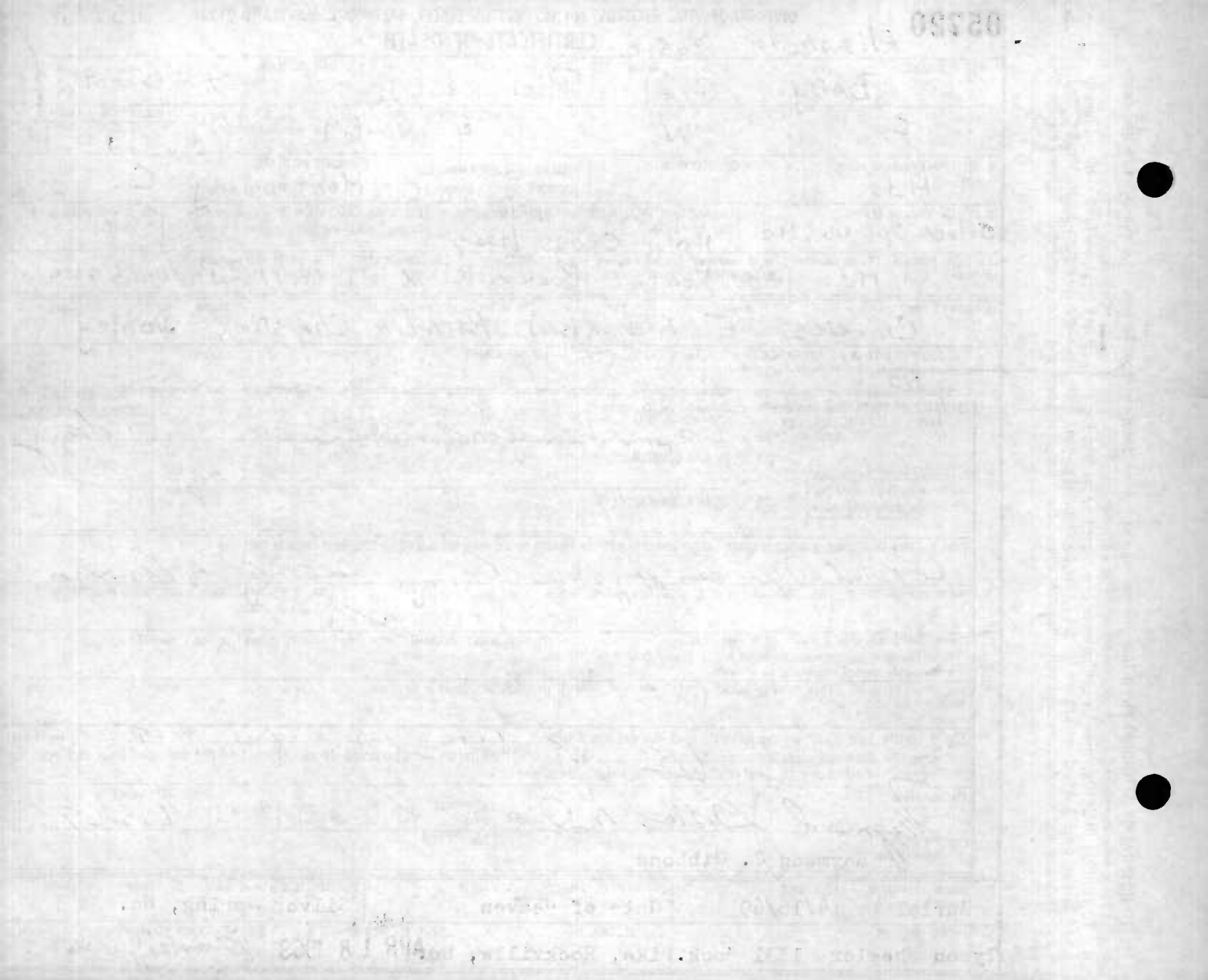
From the first through the last of the year 1954, the following amounts were received from the sale of the property:

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VR A15 (4)
30M REV. 1-68

05720		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05715	
Elizabeth Marie RICHARDSON							
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
Baby Girl Richardson				Month 4 Day 15 Year 69		2 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
F		W		4-14-69		YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Md.						Montgomery Co. Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring, Md		Holy Cross Hosp					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md		Mont.		Rockville		13e. STREET AND NUMBER	
						1411 London Lane	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Charles E Richardson		Patricia Christine Dooley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
NO							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Nerve System Damage secondary to Anoxia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-14, 1969, to 4-15, 1969, that (I) (we) last saw the deceased alive on 4-15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Raymond J. Gibbons M.D.				22c. DATE SIGNED 4-15-69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Raymond J. Gibbons							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		4/16/69		Gate of Heaven		Silver Spring, Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler 1331 Rock Pike, Rockville, Md				APR 18 1969		Charles Judge	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05721

05716

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.
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1. DECEASED-NAME (Type or Print) <i>Betty</i> First <i>Eilene</i> Middle <i>Regby</i> Last			2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <i>April</i> Day <i>8</i> Year <i>1969</i>		2b. HOUR <i>M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>June 21 1918</i>	6. AGE (In years last birthday) <i>50</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>
7a. BIRTHPLACE (State or foreign country) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. COUNTY OF DEATH <i>Montgomery</i>		9d. KIND OF BUSINESS OR INDUSTRY <i>Retired Nrs. Nurse</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>10300 West Lake Dr.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Bethesda</i>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10300 W Lake Dr.</i>			
14. FATHER'S NAME <i>Thomas Regby</i> First <i>Emma</i> Middle <i>Burley</i> Last			15. MOTHER'S MAIDEN NAME <i>Emma</i> First <i>Burley</i> Middle <i></i> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>St. Ann Mary Hosp Corps</i>		17. INFORMANT <i>Ken Emy</i> ADDRESS <i>7280 Pasaden</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fatty. Metast. Morphosis of Liver. Acute</i> <i>3032</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Chronic Alcoholism</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Sudden.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. <i></i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>April 8, 1969</i>	
EXAMINER'S NAME (Type) <i>John G Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ADDRESS (Street, city, town, or county) <i>Bethesda, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>4-11-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>	
23d. LOCATION (City or Town) <i>Suitland Pr. Geo Md</i>		23e. ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>		23f. REC'D BY REGISTRAR <i>APR 15 1969</i>	
23g. REGISTRAR'S SIGNATURE <i>Robert A Rumphrey</i>		23h. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

18520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

05722										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										057									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print) BERTHA					First ROBERTS					Last					2a. DATE OF DEATH Month 4 Day 10 Year 69					2b. HOUR 1am									
3. SEX F					4. RACE white					5. DATE OF BIRTH 1-22-1882					6. AGE (In years last birthday) 87 YRS.					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN									
7a. BIRTHPLACE (State or foreign country) NEW YORK					7b. CITIZEN OF WHAT COUNTRY? U.S.A					B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery					Md.									
10. CITY OR TOWN OF DEATH Kensington					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Md Kensington garden Home					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife					12b. KIND OF BUSINESS OR INDUSTRY At Home														
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Kensington Md					13b. COUNTY Montgomery					13c. STREET AND NUMBER 3534 Raymond Rd																			
14. FATHER'S NAME First Henry Middle Flowers Last G					15. MOTHER'S MARDEN NAME First A. Middle Edward Last Edward																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no					16b. SOCIAL SECURITY NO. UNKNOWN					17. INFORMANT Nursing Home. Records					Address														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 887X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DECUBITUS ULCERS DUE TO, OR AS A CONSEQUENCE OF (c) FRACTURED HIP															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 3 MONTHS July 1968														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION June 19 1968					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURED HIP					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year 9 PM 6-18 1969					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) SLIPPED & FELL AT HOME																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) RESIDENCE					21f. LOCATION Street or R.F.D. No. City or Town County State 3534 RAYMOND RD Kensington Md																			
22a. I certify that (I) (this hospital) attended the deceased from June , 19 68 , to April , 19 69 , that (I) (we) last saw the deceased alive on APRIL 12 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE DR LEO I DOROSAN										22c. DATE SIGNED 4/10/69					22d. PHYSICIAN'S NAME (Type) DR LEO I DOROSAN					22e. ADDRESS 8218 WISCONSIN AVE Bethesda Md									
23a. BURIAL, CREMATION, or other disposition Cremation					23b. DATE 4-12-69					23c. NAME OF CEMETERY OR CREMATORY Waterville Crematory					23d. LOCATION (City or Town) (County) (State) Waterville New York														
24. FUNERAL DIRECTOR Robert A Pumphrey										25a. REC'D BY REGISTRAR APR 15 1969					25b. REGISTRAR'S SIGNATURE [Signature]														

08782

RECEIVED IN THE RECORDS OF THE DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

OFFICE OF THE ADJUTANT GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05723

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05718

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>69</u>			2b. HOUR <u>2:30</u> P.M.		
JAMES			NMN			ROBINSON					
3. SEX MALE		4. RACE COLORED		5. DATE OF BIRTH 7- -1902			6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) MONTGOMERY GENERAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) UNKNOWN			12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BROOKEVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 19927 ZION ROAD			
14. FATHER'S NAME First Middle Last UNKNOWN			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNKNOWN		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MEDICAL RECORD DEPT.			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Extra-Cranial Hemorrhage</u> <u>4319</u> DUE TO, OR AS A CONSEQUENCE OF <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Central-Arterio sclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-22-69</u> , to <u>4-9-69</u> , that (I) (we) last saw the deceased alive on <u>4-9-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Jack Schumacher</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-9-69</u>			
22d. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.						22e. ADDRESS RUSSELL AVE., GAITHERSBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>4-12-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>AT ZION Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>MT ZION, MD.</u>					
24. FUNERAL DIRECTOR <u>R.L. Bruden Ruckelshaus</u>						25a. REC'D BY REGISTRAR DATE <u>APR 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
05724									
05719									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Elsie Irene Rogers						4 15 69			12 M
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female	White	4 - 19 - 25			43 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington San & Hosp.			Housewife			-
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Prince Georges		Lanham		YES		7203 Kempton Rd.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William McNamara			Neta Thomas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No						Joseph H. Rogers - above address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis from Ca Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ca Breast</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u> <u>14 mos</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2/21/68		Ca Breast							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan 1965, to April 15, 1969, that (I) (we) last saw the deceased alive on April 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE R. N. Sandstrom MD					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) R. N. Sandstrom MD					22e. ADDRESS 7701 Carroll Ave Takoma, Md				
23a. BURIAL, CREMATION, REBURY (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/18/69		Fort Lincoln Cem.		Colmar Manor, Md.			
24. FUNERAL DIRECTOR Name H. M. Isley's Funeral Home Inc.					ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE APR 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

12

State of Texas, County of [illegible]

I, [illegible], of the County of [illegible], State of Texas, do hereby certify that [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

(Signature)

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05725										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH										05720									
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR A				
Peter Joseph Romola										April 17, 1969					1:40 M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN				
Male			White			29 July 1914			54 YRS.										
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										
Washington, D.C.			U.S.A.						Montgomery Md.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY										
Bethesda			The Clinical Center, NIH			Electrician			U.S. Govt.										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER							
Virginia			Loudoun			Sterling			YES <input type="checkbox"/> NO <input type="checkbox"/>			804 West Poplar Road							
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last														
Joseph Romola					Talina (Unknown)														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) Yes					16b. SOCIAL SECURITY NO. 1941-46 578-09-4721					17. INFORMANT: The Medical Record Address The Clinical Center, NIH, Bethesda Md. 20014									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 15 April, 1969, to 17 April, 1969, that (I) (we) last saw the deceased alive on 17 April, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Amiel Segal, M.D.										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 17 April 1969				
22d. PHYSICIAN'S NAME (Type) Amiel Segal, M.D.										22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda Md. 20014									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 21 Apr 69					23c. NAME OF CEMETERY OR CREMATORY National Memorial Park					23d. LOCATION (City or Town) (County) (State) Falls Church, Fairfax, Virginia				
24. FUNERAL DIRECTOR Money & King Funl. Home Vienna, Va.										25a. REC'D BY REGISTRAR DATE APR 22 1969					25b. REGISTRAR'S SIGNATURE Richard Yague				

05535

RECEIVED

TO THE DIRECTOR OF THE BUREAU OF THE
INTERNAL SECURITY OF THE UNITED STATES
FROM THE DIRECTOR OF THE BUREAU OF THE
INTERNAL SECURITY OF THE UNITED STATES
SUBJECT: [Illegible]

1. [Illegible]

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18. [Illegible]

19. [Illegible]

20. [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1/64
30M REV 7/60

05726		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05721					
1. DECEASED-NAME (Type or print) First Middle Last SEMA ROSIN		2a. DATE OF DEATH Month Day Year 4 27 69			2b. HOUR 11 ⁰⁰ P M						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4/15/90		6. AGE (In years lost birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NEWFG		12b. KIND OF BUSINESS OR INDUSTRY -					
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. CITY OR TOWN MONTGOMERY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2808 Washington Ave					
14. FATHER'S NAME First Middle Last HERMAN EUGENE SHIPORNIK		15. MOTHER'S MAIDEN NAME First Middle Last TO BEY (UNK.)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 57862-44829		17. INFORMANT MRS. ELI ROSEN		Address (same as 13 above)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4310 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral vascular disease - Hypertension</u> 1 yr (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from June 1964, to April 27, 1969, that (I) (we) last saw the deceased alive on April 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Simon C. Weiner MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 28, 1969					
22d. PHYSICIAN'S NAME (Type) SIMON C. WEINER, MD		22e. ADDRESS 8201-16 th St. Silver Spring Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-29-69		23c. NAME OF CEMETERY OR CREMATORY NATL CAP. HEARST		23d. LOCATION (City or Town County State) WASH. D.C.					
24. FUNERAL DIRECTOR Holaday Funeral Home		ADDRESS 4217 9th St NW		25a. REC'D BY REGISTRAR DATE APR 30 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 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and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05727									
CERTIFICATE OF DEATH									
05722									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Robert Henry ROY						April Month 17 Day Year 1969			40A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		June 19, 1937		31 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Massachusetts		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Naval Hospital			U. S. Navy			N/A
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			St. Mary's			Lexington/		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER			Route 2, Box 107-116						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Henry Vincent Roy			Mary Louise Francoeur						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
yes 1954-1968			023-28-3244		Navy Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrotizing arteritis; confluent bronchopneumonia 4460 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 16, 1969, to April 17, 1969, that (I) (we) lost saw the deceased alive on April 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Routenberg					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 18, 1969
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
John A. Routenberg, M. D.					Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-21-69		Notre Dame Cemetery		Fall River, Mass.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. W. Chambers Co.					APR 22 1969		John A. Routenberg		
1400 Chapin Street, N.W., Washington, D.C.					DATE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS 14
45M - 1/69

05723

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05723

1. DECEASED-NAME (Type or print) <i>Lydia</i> First <i>Lydia</i> Middle <i>E.</i> Last <i>Ruedi</i>		2a. DATE OF DEATH Month <i>April</i> Day <i>30</i> Year <i>1969</i>		2b. HOUR <i>2:45</i> AM
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>8/20/15</i>	6. AGE (In years last birthday) <i>53</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban Hospital Bethesda</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Secretary - Social</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>N.T.H.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) <i>Maryland</i>	13b. CITY <i>Montgomery</i>	13c. CITY OR TOWN <i>Glen Mar Park</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>5214 Augusta Street</i>
14. FATHER'S NAME First <i>FENNER</i> Middle <i>ELLIOTT</i> Last <i>ELLIOTT</i>	15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>M.</i> Last <i>WOLLARD</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No.</i> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Joseph Ruedi - husband - add same.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>4309</i> IMMEDIATE CAUSE (a) <i>Aneurysm, ruptured, circle of Willis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>APRIL 29, 1969</i> , to <i>APRIL 30, 1969</i> , that (I) (we) lost saw the deceased alive on <i>4/29</i> <i>1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Dr. L. E. D. N. V. A. R.</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/30/69</i>
22d. PHYSICIAN'S NAME (Type) <i>DR LEO D. N. V. A. R.</i>		22e. ADDRESS <i>8215 WILKINSON AVE BETHESDA MD</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>5-3-1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montgomery Co., Md.</i>	
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, INC.</i>		25a. REC'D BY REGISTRAR <i>MAY 8 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Ruedi</i>

5130 WISC. AVE., N. W. WASH., D. C. 20016

05732

RECEIVED

1961

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05729

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05724

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <i>Ida</i> First <i>Ida</i> Middle <i>Flora</i> Last <i>Rush</i>		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <i>4</i> Day <i>30</i> Year <i>1969</i>		2b. HOUR <i>5 A</i> M
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>11/11/1875</i>	6. AGE (in years last birthday) <i>91</i> YRS.	7c. DATE PRONOUNCED DEAD <i>April 30</i> Month <i>4</i> Day <i>30</i> Year <i>1969</i>
7a. BIRTHPLACE (State or foreign country) <i>Mississippi</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>At Home</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE <i>Mississippi</i>		13b. COUNTY <i>Lauderdale</i>		13c. CITY OR TOWN <i>Meridian</i>
14. FATHER'S NAME First <i>-</i> Middle <i>-</i> Last <i>Smith</i>		15. MOTHER'S MAIDEN NAME First <i>-</i> Middle <i>UNK.</i> Last <i>-</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>425-94-9311</i>		17. INFORMANT <i>6014 CONWAY Rd. ADDRESS Bethesda, Md. Evelyn R. Mattox - daughter</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4124 Coronary Insufficiency Acute</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardio-Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John B. Bell</i> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>April 30, 1969</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal-Burial</i>		23b. DATE <i>5-1-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Magnolia Cemetery</i>
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, IN ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016</i>		23d. LOCATION (City or Town) (County) (State) <i>Meridian, Lauderdale Co., Miss.</i>		25a. REC'D BY REGISTRAR <i>MAY 6 1969</i> DATE
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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WORLD'S RECORDS

100m 11.00

200m 22.00

400m 44.00

800m 88.00

1600m 176.00

3200m 352.00

6400m 704.00

12800m 1408.00

25600m 2816.00

51200m 5632.00

102400m 11264.00

204800m 22528.00

409600m 45056.00

819200m 90112.00

1638400m 180224.00

3276800m 360448.00

6553600m 720896.00

13107200m 1441792.00

26214400m 2883584.00

52428800m 5767168.00

104857600m 11534336.00

209715200m 23068672.00

419430400m 46137344.00

838860800m 92274688.00

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 17 Film 111

4/15/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05725

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4- 5 1969			2b. HOUR P 3:00
Vincent			John			Russo			
3. SEX M	4. RACE W	5. DATE OF BIRTH 4-18-14	6. AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 4- Day 5 Year 1969	2d. HOUR P 3:00
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md.
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Book Binder-forman			12b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving U.S. Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY HATFIELD		13c. CITY OR TOWN HATFIELD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6804 Knollbrook Dr. W. Hyattsville	
14. FATHER'S NAME First Middle Last Anthony Russo				15. MOTHER'S MAIDEN NAME First Middle Last Sadie Demma					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-07-4962		17. INFORMANT ADDRESS Plumhoff Lillian Russos (Nee Plumhoff) above, wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Belden R. Reap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City or Town, County)		22b. DATE SIGNED April 5, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/9/69		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Balto., Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane				ADDRESS 31313		25a. REC'D BY REGISTRAR DATE APR 11 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05731

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05726

1. DECEASED-NAME (Type or print) BETTY Z SAGER			2a. DATE OF DEATH Month 4 Day 20 Year 69			2b. HOUR 12-24	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 3-15-1900		6. AGE (In years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY COUNTY Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY H.W.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE M.D.		13b. COUNTY PRINCE GEORGES, BELTSVILLE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11322 CHERRY HILL RD	
14. FATHER'S NAME First Middle Last JACOB JOSEPH CLARFIELD			15. MOTHER'S MAIDEN NAME First Middle Last MINNIE FINKELSTEIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 101-14-722		17. INFORMANT SAGER, HAROLD W.		Address 11366 CHERRY HILL RD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic Carcinoma -- Primary Unknown. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from April 11, 1969 , to April 20, 1969 , that (I) (we) last saw the deceased alive on April 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernard A. Heckman, M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 20, 1969	
22d. PHYSICIAN'S NAME (Type) BERNARD A. HECKMAN, MD				22e. ADDRESS 8107 EASTERN AVE, SIL. SPR. MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-21-69		23c. NAME OF CEMETERY OR CREMATORY BETH DAVID CEM.		23d. LOCATION (City or Town) (County) (State) ELMONT, LI, N.Y.	
24. FUNERAL DIRECTOR CANDACE FOUNAL HOME				ADDRESS 421 79TH ST NW		25a. REC'D BY REGISTRAR APR 23 1969	
				25b. REGISTRAR'S SIGNATURE Bernard A. Heckman			

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OFFICE OF THE
SECRETARY OF THE AIR FORCE
WASHINGTON, D.C.

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JAN 10 1964
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OFFICE OF THE
SECRETARY OF THE AIR FORCE
WASHINGTON, D.C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 23 Film 412
4/30/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05732

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05727

1. DECEASED-NAME (Type or Print) <i>Peter</i> First <i>P</i> Middle <i>Santianni</i> Last		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <i>April 21</i> 19 <i>69</i> Month <i>April</i> Day <i>21</i> Year <i>1969</i>		2b. HOUR <i>1:30</i> M				
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Sept. 6, 1926</i>	6. AGE (In years last birthday) <i>42</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	2c. DATE PRONOUNCED DEAD Month <i>April</i> Day <i>21</i> Year <i>1969</i>	2d. HOUR <i>1:30</i> P M	
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>ARCHITECT</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>10500 Rockville Pike</i>
14. FATHER'S NAME First <i>Michael</i> Middle <i>Santianni</i> Last <i>Santianni</i>		15. MOTHER'S MAIDEN NAME First <i>Adeline</i> Middle <i>Santianni</i> Last <i>Santianni</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16b. SOCIAL SECURITY NO. <i>4-109-111111</i>		17. INFORMANT <i>B. L. Santianni</i> ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) <i>4109</i> stating the underlying cause lost. } (b) <i>Coronary arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. <i></i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>April 22, 1969</i>		
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-26-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>		23d. LOCATION (City or Town) <i>Yeadon, Penna.</i> (County) <i>Philadelphia</i> (State) <i>Penn.</i>		
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. RECEIVED BY REGISTRAR <i>APR 23 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR 15-14
45M 1969

05738		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05728	
1. DECEASED-NAME (Type or print) First Middle Last				2a. DATE OF DEATH	
MARY MNM SARGENT				16 Month Day Year 1969	
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		CAUC		15 MARCH 1903	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
PENNSYLVANIA		U.S.A.		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
BETHESDA		NAVAL HOSPITAL		HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. STREET AND NUMBER	
VIRGINIA		ARLINGTON		4990 COLUMBIA PIKE, APT 409	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
UNKNOWN		UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Address	
				Hospital records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1890 Metastatic Carcinoma of the Kidney					
DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from 2 FEBRUARY 19 69, to 16 APRIL, 19 69, that (X) (we) last saw the deceased alive on 16 APRIL, 19 69, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (and) (doctor) view the body after death.					
22b. SIGNATURE Robert E. Chambers, MD DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 17 Apr 1969	
22d. PHYSICIAN'S NAME (Type) ROBERT E. CHAMBERS LT MC USN				22e. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4-19-69		Mt. Wolloston Cemetery	
				Quincey, Mass	
24. FUNERAL DIRECTOR		ADDRESS		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Home Ave. Bethesda, Md.		7757 Wisconsin		Charles Judge	
		DATE APR 21 1969			

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U.S. DEPT. OF STATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR	
MARY		PHIL	HOWARD	SCHIEFER	4-8-69			8:52AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
F	W		1-13-74		95 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNA.		U.S.A.				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		WASH. SAN. & HOSP.		NONE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MO.		MONTG.		BETHESDA		YES		7809 Chelton Road	
14. FATHER'S NAME First Middle Lost		15. MOTHER'S MAIDEN NAME First Middle Lost							
JOHN W SNYDER		ELIZABETH TYGER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO				DAUGHTER, 7809 Chelton Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Vascular Insufficiency</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>yes</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Severe decubital & infection</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 15, 1966</u> , to <u>April 8, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 7, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>Harold W. Draper, M.D.</u>		<u>4/8/69</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
HAROLD W. DRAPER M.D.		9501 GEORGIA AVE, SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-10-69		Union Cemetery		Rossiter, Penna.			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Humphrey		7557 Wisc		APR 15 1969		<u>Robert A. Humphrey</u>			

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Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

VR A15
45M -

DATE **APR 22 1969**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05736		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05731			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Harry William Schoening						Apr. 12, 1969		9:15 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
male		white		10/8/1886		82 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Pennsylvania		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton		Univ. Nursing Home		Veterinarian					
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
STATE		13b. COUNTY		Washington D.C.				5504 Nebraska Ave. N.W.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Harry Schoening						Sarah Frank			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address
yes		WW1		579-60-3346		William Rech-700 Welsh Rd. Apt. B-16			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebrovascular Accident							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4379		DUE TO, OR AS A CONSEQUENCE OF							10 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Cerebral Arteriosclerosis							See you
		(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Myocarditis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
None									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this-hospital) attended the deceased from Jan. 1969, to Apr. 12, 1969, that (I) (we) last saw the deceased alive on Apr. 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Lynwood Heiges, M.D.		4/12/69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
		LYNWOOD HEIGES, M.D., F.A.C.A.							
		15015 Flower Valley Court							
		Rockville, Maryland 20853							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
burial		4/16/69		Arlington National		Arlington, Virginia			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
The S.H.Hines Co. Washington, D.C.						APR 16 1969		Charles Judge	

05732

UNITED STATES GOVERNMENT - WASHINGTON, D.C.

OFFICE OF THE SECRETARY

BE

10/1/50

WASH

10/1/50

MEMORANDUM

TO :

FROM :

SUBJECT :

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

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18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

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29. [Illegible]

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64. [Illegible]

65. [Illegible]

66. [Illegible]

67. [Illegible]

68. [Illegible]

69. [Illegible]

70. [Illegible]

71. [Illegible]

72. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15
30M REV.

05737										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05732									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
Baby Boy Seal										4 Month 01 Day 1969 Year					6.20 PM														
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. HOURS MIN.														
Male			White			3.30.69						2 DAYS																	
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Maryland					United States										Montgomery Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Olney					Montgomery General																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
Md					Montgomery					Derwood					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					5904 Muncaster Mill Rd									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
Milford Seal					Ruthie Estelle Parks																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
no					None					Hospital Records																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u>															28.														
DUE TO, OR AS A CONSEQUENCE OF <u>Prematurity (4 lb)</u>															26.														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					yes														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					City or Town County State														
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No.																			
22a. I certify that (I) (this hospital) attended the deceased from <u>3:30</u> , 19 <u>69</u> , to <u>4:11</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED									
																				4/2/69									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
Charles H. Ligon M.D.										Sandy Spring, Md.																			
23a. BURIAL, CREMATION, or other (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					April 3 1969					Seal Farm					Etchison Mont. Md.														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
Francis H. Barber										DATE APR 7 1969																			
Laytonville Md.																													

05737

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None Hospital - records

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Partial Francis H. Barber
April 3 1959 Coal Farm
Laytonville Id. 1959 7 1959
Stichison Mont.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14
05738

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05733

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last RICHARD A. SEBASTIAN JR.			2a. DATE OF DEATH Month Day Year 4 28 69			2b. HOUR 5 15 PM						
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH 3-4-1897		6. AGE (in years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS 1 25		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) ILL.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2015 E.W. Highway			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5912 Wilmet Road			
14. FATHER'S NAME First Middle Last EDICK Scheroubt			15. MOTHER'S MAIDEN NAME First Middle Last Normal CHANDLER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 443-14-3804A			17. INFORMANT CHEVY Chase Nsg. & Contr. Center			Address Silver Spring			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis of Cerebral Arteries DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1991 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs Indefinite year												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None												
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1964, 19, to 4/28/69, 19, that (I) (we) last saw the deceased alive on 4/28/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE Robert A. Pumphrey						DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 4/28/69		
22d. PHYSICIAN'S NAME (Type) Dr. William P. Argy M.D.						22e. ADDRESS 3001 Conn Ave Washington DC						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 5-1-69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City or Town) (County) (State) Suitland, Pr. Geo. Md.				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a. REC'D BY REGISTRAR MAY 5 1969			25b. REGISTRAR'S SIGNATURE Charles J. Jones			

65733

STATE OF DEATH

DEPARTMENT OF HEALTH & HUMAN SERVICES



1

U.S. GOVERNMENT PRINTING OFFICE: 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05739					05734				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR P	
Georges Jack Serabian					April 3 1969			4:25 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		12 March 1921		48 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center			Attorney			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9216 Jones Mill Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
John Serabian			Elise Boyajian						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
Yes			WW II		The Medical Records Address				
			128-01-8627		The Clinical Center, NIH, Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma								1 Year	
2001 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work				Street or R.F.D. No.					
22a. I certify that (X) (this hospital) attended the deceased from 17 March, 1969, to 3 April, 1969, that (I) (we) last saw the deceased alive on 3 April, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Sherrard L. Hayes, M. D.								3 April 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
				The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		4/7/69		Gate of Heaven Cemetery		Silver Spring, Maryland			
24. FUNERAL DIRECTOR				5130 Wisconsin Ave., N.W.		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph Gawler's Sons, Washington, D.C.						APR 7 1969		J. J. Judge	

08730

CENTRAL DE DEAR

UNITED STATES DEPARTMENT OF JUSTICE

10/1/50

One of several cemeteries, including
St. Mary's, is located in the
vicinity of the site of the
bombing of the ship, and the
remains of the ship are
located in the vicinity of the
site of the bombing.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05740		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05735			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Odyce					Shaw	4	17	69	2330M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birth day)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		CAUC.		7-18-84		84 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MISSOURI		U.S.A.				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		CARRIAGE Hill E.C.F.		HOUSEWIFE		N.A.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
D.C.		D.C.		WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4550 BRANDYWINE ST.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
HENRY					KAUFMAN	ANN			(UNKNOWN)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
-			579-60-7794		ARNOLD SHAW, SON,		4550 BRANDYWINE ST. NW WASH, D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT, ACUTE 8 WEEKS.									
4109 DUE TO, OR AS A CONSEQUENCE OF ARTERY									
(b) CORONARY THROMBOSIS									
DUE TO, OR AS A CONSEQUENCE OF									
(c) CORONARY ARTERY ATHEROSCLEROSIS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
DIABETES MELLITUS, CONGESTIVE HEART FAILURE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
N.A.		N.A.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		N.A.			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
10:15 A.M.		N.A.		N.A.					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
N.A.		N.A.		N.A.		N.A.			
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 69, to 17 APR 19 69, that (I) (we) last saw the deceased alive on 17 APRIL 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Donald B. Doty M.D.						17 APRIL 69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
DONALD B. DOTY						1909 HANOVER ST., SILVER SPRING			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REC'D BY REGISTRAR	
Cremation		4-21-1969		Cedar Hill Crematory		Suitland, Prince Georges Co. Md.		DATE APR 23 1969	
24. FUNERAL DIRECTOR						25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE	
JOSEPH GAWLER'S SON, INC.						P. Chas. Judge			
5130 WISC. AVE. N. W. WASH., D. C. 20016									

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RECEIVED

OFFICE OF THE ATTORNEY GENERAL

Exemption # 21-1962 Cedar Hill Crematory Building, El Paso, El Paso Co., Tex.

APR 2 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05741				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05736					
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) PEARL				First Middle Last				2a. DATE OF DEATH				2b. HOUR	
				SHRADER				Month 4 - Day 15 Year 1969				10:30AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 4-10-1882				6. AGE (In years 87 birthday Yrs.)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				Md.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Stenographer				12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 653 East Capitol St. S.E.					
14. FATHER'S NAME First Middle Last Peter Shrader				15. MOTHER'S MAIDEN NAME First Middle Last Susan Hartman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 579-60-4683		17. INFORMANT Address Wash., D.C. Mrs. Jessie E. Smith, 5410 Conn. Ave. N.W.,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis										12 hr			
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Coronary Artery Disease										over 5 yrs.			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebral Vascular Thrombosis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Oct , 1962, to April 15 , 1969, that (I) (we) last saw the deceased alive on April 15 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Louis H. Shuman, M.D.				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-15-69					
22d. PHYSICIAN'S NAME (Type) Louis H. Shuman, M.D.				22e. ADDRESS 1635 Mass. Ave. N.W., Wash., D.C.,									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-18-1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co. Md.					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE O'Connell Judge							

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05742

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05737

1. DECEASED-NAME (Type or Print) HARRY H SILVERMAN			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month 4 Day 24 Year 69			2b. HOUR 6:16 M A	
3. SEX M	4. RACE WH	5. DATE OF BIRTH 12/13/92	6. AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 4 Day 24 Year 19 69	
7a. BIRTHPLACE (State or foreign country) ROUMANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH SILVER SPRING Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MERCHANT (RET.)		12b. KIND OF BUSINESS OR INDUSTRY GROCERY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME SOLOMON		15. MOTHER'S MAIDEN NAME BERTHA BROUNSTEIN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			
16a. SOCIAL SECURITY NO. 578-367125		17. INFORMANT STYLIA SILVERMAN		14119 - ADDRESS CHESTERFIELD, MD. ROCKVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 12 4-6 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased sealed self in hot bath water			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State (Above) Rockville Montgom. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN REAP, MD.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/24/1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/27/69		23c. NAME OF CEMETERY OR CREMATORY NATL. MEM. PARK		23d. LOCATION (City or Town) (County) (State) FALLS CHURCH, VA.	
24. FUNERAL DIRECTOR GOLDBERG FUNERAL HOME		ADDRESS 926 ST. N.W.		25a. REC'D BY REGISTRAR DATE APR 28 1969		25b. REGISTRAR'S SIGNATURE Charles Jones	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

05743

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05738

1. DECEASED-NAME (Type or Print) ROBERT HENRY SIMMONS			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> April 25, 1969			2b. HOUR 2:10 PM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 10, 1900	6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month April Day 25 Year 1969			2d. HOUR 2:10 PM			
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Takoma Park,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Chemist - Gov't Printing Office			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Mont.		13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 513 Margaret Drive					
14. FATHER'S NAME Charles Simmons			First Middle Last			15. MOTHER'S MAIDEN NAME Annie Perkins			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Mary Simmons			ADDRESS ----- Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Dis. DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Belden R. Reap			EXAMINER'S NAME (Type) Belden R. Reap, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED April 25, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE April 29, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory			23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland				
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.			25a. REC'D BY REGISTRAR DATE APR 29 1969			25b. REGISTRAR'S SIGNATURE Richard A. Judge						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05744		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05739	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Walter Franklin Simons			2a. DATE OF DEATH 4 Month 9 Day 69 Year			2b. HOUR 12 45 A M	
3. SEX male		4. RACE Cav.		5. DATE OF BIRTH July 9, 1883		6. AGE (In years last birthday) 85 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Nsg Home, 5721 Grosvenor		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Glen Echo		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Walter Thomas Garland Simons		15. MOTHER'S MAIDEN NAME First Middle Last Barbara Ann Butler		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. 228-44-6278-J		17. INFORMANT (219 20770) J. Wilson Howard Simons		Address 9308 Edmondston Rd Greenbelt, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF death heart failure (b) and aneurysm of aorta DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years 4 wks							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-8-1969, 1969, to 4-8-1969, that (I) (we) last saw the deceased alive on 4-8-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. P. Ryland		22c. DATE SIGNED 4-9-69		22d. PHYSICIAN'S NAME (Type) C. P. RYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/9/69		23c. NAME OF CEMETERY OR CREMATORY Good Hope Baptist Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Spotsylvania, Co.	
24. FUNERAL DIRECTOR S.H. Hines Co. Funeral Home		24b. ADDRESS Tel. Co. 5-7023 Wash. D.C. 290144 St NW		25a. REC'D BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE John J. Jones	

02745

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FEDERAL BUREAU OF INVESTIGATION

1

1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Federico			Paragas			SINLAO			April 17 1969 135A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Malaysian		18 August 1927		41 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Philippine Islands		Philippines				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Naval Hospital			Philippine Navy			N/A
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
P. I.					Quezon City		YES <input type="checkbox"/> NO <input type="checkbox"/>		191 Ermin Garcia, Cubao
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Donato Sinlao			Paula Paragas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			NONE		Navy Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatoma with bile peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Status postoperative laporotomy</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 15</u> , 19 <u>69</u> , to <u>April 17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>D. L. Colgan</u> M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 17, 1969		
22d. PHYSICIAN'S NAME (Type) D. L. Colgan, M. D.					22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-23-69		Layola Memorial Park		Manilla Philippine Island			
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N.W., Washington, D. C.					25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <u>Clady</u>			First <u>-</u> Middle <u>-</u> Last <u>Slaver</u>			2a. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1969</u>			2b. HOUR <u>12</u> P.M. <u>45</u>	
3. SEX <u>Female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>9-1-03</u>			6. AGE (In years last birthday) <u>65</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	IF UNDER 24 HRS. HOURS <u> </u> MIN <u> </u>
7a. BIRTHPLACE (State or foreign country) <u>Georgia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Montgomery</u> Md.			
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanitarium & Hosp. Inc.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u> </u>			12b. KIND OF BUSINESS OR INDUSTRY <u> </u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>D.C.</u>			13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Washington D.C.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>6806 laurel Street</u>	
14. FATHER'S NAME First <u>John</u> Middle <u> </u> Last <u>Slaver</u>			15. MOTHER'S MAIDEN NAME First <u>Hemmie</u> Middle <u> </u> Last <u>Little</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service) <u> </u>				
16b. SOCIAL SECURITY NO. <u> </u>			17. INFORMANT <u>Records - Washington Sanitarium & Hosp. Inc.</u> Address <u> </u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 month</u> <u>years</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Osteoporosis - Severe hypophosphatemia</u>										
19a. DATE OF OPERATION <u> </u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u> </u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> P.M. <u> </u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <u> </u>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u> </u>			21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr. 24</u> , 19 <u>68</u> , to <u>Apr. 22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Apr. 22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Philip E. Jones M.D.</u>					DEGREE <u> </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/22/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Philip E. Jones M.D.</u>					22e. ADDRESS <u>800 Pershing Drive Silver Spring Md. 20910</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 25, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rick Creek Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Washington</u> <u> </u> <u> </u>			
24. FUNERAL DIRECTOR <u>Takoma Funeral Home Inc. J.A. Walter</u>					ADDRESS <u>254 Carroll Rd NW</u>		25a. REC'D BY REGISTRAR <u>APR 24 1969</u>			25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>

05250

RECORDS OF DEATH

DEPARTMENT OF HEALTH

APR 2 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05747 CERTIFICATE OF DEATH 05742									
1. DECEASED-NAME (Type or print) First Middle Last Sherwood F. Smith					2a. DATE OF DEATH Month Day Year April 23 1969			2b. HOUR 11:45	
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 24, 1906		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4 N. Summit Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Owner		12b. KIND OF BUSINESS OR INDUSTRY Farm machinery			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4 N. Summit Drive	
14. FATHER'S NAME First Middle Last Hench Ezra Marcellus Smith			15. MOTHER'S MAIDEN NAME First Middle Last Hester Feaga						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214 09 2427		17. INFORMANT Mrs. Mildred Smith, 4 N. Summit Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1958 , 19 19 , to 4/23 , 19 69 , that (I) (we) last saw the deceased alive on 4/7 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L. I. Leal M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 24, 1969	
22d. PHYSICIAN'S NAME (Type) L. I. Leal M.D.				22e. ADDRESS Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 26, 1969		23c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		23d. LOCATION (City or Town) (County) (State) Frederick Frederick Md.			
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick		25a. REC'D BY REGISTRAR APR 28 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

05747

DEPARTMENT OF STATE

APR 28 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-14
30M REV 1-68

05748

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05743

1. DECEASED-NAME (Type or print) Anne Kane SNEERINGER			2a. DATE OF DEATH April Month 29 Day 69 Year			2b. HOUR 1230 PM					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH December 4, 1915		6. AGE (In years last birthday) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia			13b. COUNTY Fairfax		13c. CITY OR TOWN McLean		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6635 Hazel Lane		
14. FATHER'S NAME Matthew KANE			15. MOTHER'S MAIDEN NAME Marian HOFFA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 172 01 0156		17. INFORMANT McLean Col. Earl A. Sneeringer,			Address Virginia 6635 Hazel Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from <u>Mar. 3</u> , 19 <u>69</u> , to <u>Apr. 29</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>Apr. 29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>P. B. Blanchard</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Apr. 30, 1969			
22d. PHYSICIAN'S NAME (Type) P. B. BLANCHARD, M. D.						22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/2/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.					
24. FUNERAL DIRECTOR Falls Church Funeral Home 1102 West Broad St., Falls Church, Va.						25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

32720

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05749 CERTIFICATE OF DEATH 05744									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A M
Charles McNeal South						April 30 1969			4:50 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		White		20 November 1932		36 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center			T. V. Repairman			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Virginia					Roanoke		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4948 Northlake Drive, N. W.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Walter G. South						Bess Dunn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			Not available		The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia with respiratory failure									1 month
2050 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myelogenous leukemia									6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Recurrent pseudomonas septicemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (this hospital) attended the deceased from 27 January, 1969, to 30 April, 1969, that (we) last saw the deceased alive on 30 April, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Ira Goldstein</i> H.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 30 April 1969			
22d. PHYSICIAN'S NAME (Type) Ira M. Goldstein, M.D.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		3-May 69		Bland Cemetery			Bland Virginia		
24. FUNERAL DIRECTOR 7557 Wisconsin Ave Bethesda, Md						25a. REC'D BY REGISTRAR DATE MAY 5 1969		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	
Robert A Pumphrey									

05743

STATE OF DEATH

NAME	John	John	John
DATE	1900	1900	1900
TIME	10:00	10:00	10:00
PLACE	At home	At home	At home
CAUSE	Heart failure	Heart failure	Heart failure
AGE	70	70	70
SEX	Male	Male	Male
RELIGION	Protestant	Protestant	Protestant
EDUCATION	High School	High School	High School
OCCUPATION	Farmer	Farmer	Farmer
RESIDENCE	123 Main St.	123 Main St.	123 Main St.
CITY	Springfield	Springfield	Springfield
STATE	Illinois	Illinois	Illinois
COUNTY	Clark	Clark	Clark
ZIP	62701	62701	62701
DEATH CERTIFICATE	Yes	Yes	Yes
TESTIMONY	Yes	Yes	Yes
WITNESSES	Yes	Yes	Yes
DATE	1900	1900	1900
TIME	10:00	10:00	10:00
PLACE	At home	At home	At home
CAUSE	Heart failure	Heart failure	Heart failure
AGE	70	70	70
SEX	Male	Male	Male
RELIGION	Protestant	Protestant	Protestant
EDUCATION	High School	High School	High School
OCCUPATION	Farmer	Farmer	Farmer
RESIDENCE	123 Main St.	123 Main St.	123 Main St.
CITY	Springfield	Springfield	Springfield
STATE	Illinois	Illinois	Illinois
COUNTY	Clark	Clark	Clark
ZIP	62701	62701	62701
DEATH CERTIFICATE	Yes	Yes	Yes
TESTIMONY	Yes	Yes	Yes
WITNESSES	Yes	Yes	Yes

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05750

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05745

1. DECEASED-NAME (Type or Print) HARRY CHARLES SPARSHOTT			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> 4-24-1969			2b. HOUR 3:45 AM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 4-4-06	6. AGE (In years last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS OAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 4 Day 24 Year 1969			2d. HOUR 3:45 AM
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Service Dept.			12b. KIND OF BUSINESS OR INDUSTRY Wash. Gas Light	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9316 Ocala St.	
14. FATHER'S NAME First Charles Middle H. Last Sparshott			15. MOTHER'S MAIDEN NAME First Cora Middle Mae Last Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. yes		17. INFORMANT Linda Miller			ADDRESS Newport News, 11510 Warwick Blvd., Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 441.2 Cardiac Arrest secondary to DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) leaking Abdominal Aortic DUE TO, OR AS A CONSEQUENCE OF (c) Aneurysms								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 4-24-1969		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Leaking abdominal aortic aneurysm, cardiac arrest during surgery				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) surgery					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) Belden R. Reap, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 28, 1969		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION (City or Town) (County) (State) Hyattsville, Maryland		22b. DATE SIGNED April 24, 1969	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc., Silver Spring, Maryland				25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Occupation		Cause of Death		Manner of Death	
Residence		Signature of Physician		Signature of Medical Examiner		Signature of Coroner	
Date of Examination		Time of Examination		Place of Examination		City and State	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05751

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05746

1. DECEASED-NAME (Type or print) DANA ASHTON Sprague			2a. DATE OF DEATH Month 4 Day 1 Year 69			2b. HOUR 3 AM	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 6-24-03		6. AGE (In years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wheaton Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY SHOES	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3702 Manor Rd							
14. FATHER'S NAME First HARRY Middle RALPH Last SPRAGUE			15. MOTHER'S MAIDEN NAME First BESSIE Middle — Last RICH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 014-10-2200A		17. INFORMANT Address V. FERN SPRAGUE - SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 185X Uremia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Kidney failure DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of prostate							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerosis							
19a. DATE OF OPERATION 2/17/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of prostate		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 8, 1965 , to March 18, 1969 , that (I) (we) last saw the deceased alive on 3/26/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John B. Umhau				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/1/69	
22d. PHYSICIAN'S NAME (Type) JOHN B. UMHAU				22e. ADDRESS 8805 Conn Ave. Chevy Chase, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/3/69		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.		23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MD.	
24. FUNERAL DIRECTOR ESS. GAULER'S SONS				ADDRESS 3130 WIS. AVE., N.W.		25a. REC'D BY REGISTRAR DATE APR 7 1969	
						25b. REGISTRAR'S SIGNATURE Charles Judge	

08751

(RECEIVED OF DEATH)

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RELATIONSHIP TO DECEASED

SIGNATURE OF DECEASED

SIGNATURE OF WITNESS

SIGNATURE OF JUDGE

DATE OF SIGNATURE

PLACE OF SIGNATURE

REMARKS

REMARKS

REMARKS

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REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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45M - 189

05752		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05747					
1. DECEASED-NAME (Type or print) <i>Edith B. Stevens</i>				First Middle Last		2a. DATE OF DEATH Month <i>April</i> Day <i>5</i> Year <i>1969</i>				2b. HOUR <i>2:20 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>Dec. 14, 1903</i>		6. AGE (In years last birthday) <i>65</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>				Md.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>209 Kimblewick Drive</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>209 Kimblewick Drive</i>			
14. FATHER'S NAME First Middle Last <i>Clarence H. Miller</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Mattie Strite</i>				Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No.</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>578-09-3601B</i>		17. INFORMANT <i>Mitchell Stevens</i>				Address <i>-209 Kimblewick Dr., S.S.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4123 Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart Disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> <i>6 years</i> <i>10 years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>4/10/69</i> , 19____, to <i>4/15/69</i> , 19____, that (I) (we) lost the deceased on <i>4/15/69</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John J. Curry MD.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>April 5, 1969</i>					
22d. PHYSICIAN'S NAME (Type) <i>Dr. John J. Curry</i>				22e. ADDRESS <i>9801 Georgia ave. Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-8-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ford Lincoln cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington D.C.</i>					
24. FUNERAL DIRECTOR <i>Paul J. Smith</i> <i>Warner E. Pumphrey</i>				ADDRESS <i>8434 Ga. ave. Sil. Spr. Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 11 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>			

05732

STREET OF SEVEN

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Dec. 14, 1907

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05753

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05748

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b. HOUR
HARRY						STOLAR		<input checked="" type="checkbox"/> 4		4	2	1969	6:40A
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years at birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month		Year	2d. HOUR
Male	White	5/20/88		80						Month		20y	6:40A
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Lithuania		USA				Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital		merchant		Retired						Grocery	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland		Montgomery		Sil. Sprg.				1220 E. W Hwy		SSMd.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
David						Stolar		Mildred				Ruth	
												Abrams	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT						ADDRESS	
yes		WWI				wife Ida- 1220 E.W Hwy SSMd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic Heart Disease</u> (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Belden R. Reap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		BELDEN R. REAP		M.D.		ADDRESS (City, Town, or county)		APRIL 2, 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		4-4-69		B'nai Israel Cemetery		Oxon Hill, Maryland							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Bernard Romanovsky		3501 14th St		DATE APR 7 1969		Charles Judge							

00123

MEAL TANKING CERTIFICATE OF DEATH

NAME	AGE	SEX	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DIAGNOSIS	TESTS	TREATMENT	REMARKS

Ante Coram
Ante Coram

X

X X

Allen B. [Signature]
Allen B. [Signature]

APR 2, 1961
APR 2, 1961

APR 1 1961
APR 1 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05754

CERTIFICATE OF DEATH

05749

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5503 Cromwell Drive		d. STREET ADDRESS 5503 Cromwell Drive	
3. NAME OF DECEASED (Type or print) First Middle EDWIN WALTER STROMWALL		4. DATE OF DEATH Month Day Year April 11, 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1908
9. AGE (In years lost birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service manager		10b. KIND OF BUSINESS OR INDUSTRY U. S. Steel	
11. BIRTHPLACE (County & State, or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Axel Stromwall		14. MOTHER'S MAIDEN NAME Elfreda Larson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 323-01-3994	
17. INFORMANT Dorothy L. Stromwall, Bethesda, Maryland		Address 5503 Cromwell Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 DIFFUSE CARCINOMA WITH DUE TO INTESTINAL BLEEDING Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA, PRIMARY UNKNOWN (c) 9 months		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 , to 4-11 , 19 69 , that (I) (we) last saw the deceased alive on 4-10 , 19 69 , and that death occurred at 3:20 A M, from causes and on the date stated above.			
22a. SIGNATURE - Richard B. Perry MD		22b. DATE SIGNED 4-11-69	
22c. PHYSICIAN'S NAME (Type) Richard B. Perry		22d. ADDRESS 2001 Eye St., N. W. Washington D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF April 11, 1969	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Joseph Gawler's Sons Washington D. C. 20016		25a. REC'D BY REGISTRAR APR 15 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge			

05754

Montgomery

Montgomery

Montgomery

Bedford

Bedford

2505 Greenwell Drive

2505 Greenwell Drive

April 11, 1969

EDWIN

WALTER

EDWIN

X

February 13, 1968

White

White

U. S. A.

Chicago, Illinois

U. S. Steel

Service manager

Eliza Larson

Eliza Larson

2505 Greenwell Dr.

2505 Greenwell Dr., Bedford, Maryland

103-01-2004

10

2001 Eye St., N. Washington D. C.

Richard B. Perry

Shiloh, Maryland

April 11, 1969 Cedar Hill Elementary

Shiloh

2130 Alacorn Avenue N. W.

Joseph Gaudin's Sons Washington D. C. 20016

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
<div>05755</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>05750</div>														
1. DECEASED-NAME (Type or Print)					First		Middle		Last					
Carl					H.		Stutler							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male		Cauc.		May 4, 1899		69 YRS.		MONTHS		DAYS				
								HOURS		MIN.				
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					2c. DATE PRONOUNCED DEAD				
W. Virginia					U.S.A.					2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 4 - 29 69				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				
Silver Spring					11305 New Hamp. Ave.					Carpenter Contractor Building				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN				
Maryland					Montgomery					Sil. Spr.				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				
Jasac					W. Stutler					Minnie Radabaugh				
16b. SOCIAL SECURITY NO.					17. INFORMANT					17. ADDRESS				
401X					Grace O. Stutler					10305 New Hampshire Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Essential Hypertension														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b)														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day, Year					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
					HOUR A.M. P.M.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED				
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					April 29, 1969				
Belden R. Reap, M. D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
					ADDRESS (City, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY				
Burial					May 3, 1969					I.O.O. F. Cemetery				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Warner E. Pumphrey, Inc.					MAY 5 1969					Charles Judge				

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05756		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						05751	
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
Donald P. Stutler								Month Day Year 4-24 1969	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		2c. DATE PRONOUNCED DEAD	
Male	Cauc.	11-17-1951		17 YRS.		MONTHS DAYS HOURS MIN		Month Day Year 4 24 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Rear - Tak. Park Academy							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Virginia		V		Vienna		YES <input type="checkbox"/> NO <input type="checkbox"/>		346 Court House Road	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Donald E. Jones								Ethel Jones	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No						Father		Vienna, Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Multiple Extreme Injuries including Fractured									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Skull with Exsanguination									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		3:15 P.M. 4-24-1969		Deceased, operating bulldozer, pinned under it when it overturned.					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
		Field - Constr. Site		Rr. Tak. Pk. Academy		T.P. Montgomery		Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Belden R. Reap, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		Belden R. Reap, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		April 24, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/28/69		Flint Hill		Oakton, Virginia			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Money & King Vienna Funeral Home Vienna, Va.				DATE APR 28 1969		J Charles Judge			

02520

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 15 Form 112 5/2/69 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05757 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												05752			
1. DECEASED-NAME (Type or Print) First Middle Last JESSE JAMES SWEAT JR						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year APR 17 1969						2b. HOUR 11:45 PM			
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH OCT 21, 1952		6. AGE (In years last birthday) 16 YRS.		IF UNDER 1 YEAR MONTHS DAYS 16		IF UNDER 24 HRS. HOURS MIN. 16		2c. DATE PRONOUNCED DEAD Month Day Year APR 17 1969		2d. HOUR 11:45 PM	
7a. BIRTHPLACE (State or foreign country) FLORIDA				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STUDENT				12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE VIRGINIA				13b. COUNTY PRINCE WILLIAMS				13c. CITY OR TOWN WOODBRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 841 HALIFAX RD			
14. FATHER'S NAME First Middle Last JESSE JAMES SWEAT Sr						15. MOTHER'S MAIDEN NAME First Middle Last Iris LULA/ Gwendolyn PARRISH Dicks									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT ADDRESS HOSPITAL RECORDS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration, maceration of brain DUE TO, OR AS A CONSEQUENCE OF (b) gunshot wound to head (self-inflicted) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 6:00 P.M. Apr 16 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot self in head 22 caliber rifle							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. City or Town County State 841 Halifax Rd. Woodbridge, Pr. Wm. Va.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE John G. Ball						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b. DATE SIGNED 18 April 1969			
EXAMINER'S NAME (Type) John G. BALL, M.D.						ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 21 Apr. 69		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.					
24. FUNERAL DIRECTOR Cunningham Mountcastle								25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 10-22a Film 412 Maryland State Department of Health 5-12-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										05753													
1. DECEASED-NAME (Type or Print)			First			Middle			Last			2a. DATE KNOWN OF DEATH			2b. HOUR								
MiyaKo			O			TaKeta						<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 4/29 1969			10A M								
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR								
Fe		Japanese		Jan 15, 1909		60 YRS.		MONTHS		DAYS		Month Day Year April 29 1969			10:57 A M								
7a. BIRTHPLACE (country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH														
Washington			U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery						Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY														
Bethesda			Suburban			Housewife			Own home														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER											
Maryland			Montgomery			Kensington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			11212 Woodson			XXXXXX								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																				
Shingiro			Okada			Yone			Tange														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS														
No			YES 268-24-1698			Husband Chiyoto Taketa			SAME														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PT-ADIPHA Barbiturate poisoning</u> 9800 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Overdose of barbiturate</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														1/2 hr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?											
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
						8:30 P.M. 4/29 19 69						Took overdose of barbiturate											
21d. INJURY OCCURRED						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State											
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						Home						1112 Woodson St. Kensington Montg. Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>																							
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) John G. Ball, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)						22b. DATE SIGNED APRIL 29 1969											
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)					
Cremation						May 2, 1969						Fort Lincoln Crematory						Bladensburg, Maryland					
Funeral Director: E. Glen Carter						8434 Georgia Avenue						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc.						Silver Spring, Maryland						MAY 5 1969						Charles Judge					

00553

WILSON, J. H. (Jr.)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
05759					05754												
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					2b. HOUR							
First			Middle		Last		Month			Day		Year		315		M	
Florence			LaQue		Tankersley		April			9		1969					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female			White - Caucasian			1-10-93			76			YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Penn.			America						Montgomery								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Takoma Park			Hash. San. Hosp.			None - Housewife			Own Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
D.C.			136			Hash., D.C.						7905 13th St., N.W.					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
First Middle Last			First Middle Last														
Thomas			Bitchell			Hinnie Andrus											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT											
No			1-25-95-3			Thomas M. Gittings, Jr. Address 806-15th St., N.W. Patient's chart 520 SHOREHAM BLDG., D.C.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
531.0 Shock															12 hours		
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
(b) Upper gastrointestinal hemorrhage															3 1/2 days		
DUE TO, OR AS A CONSEQUENCE OF																	
(c) Gastric ulcer															1 month		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
Intermittent heart disease																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Oct. 1960, to Apr. 8, 1969, that (I) (we) last saw the deceased alive on Apr. 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Serush T. Kimble M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 4-8-69																	
22d. PHYSICIAN'S NAME (Type) Serush T. Kimble 22e. ADDRESS 7801 Georgia Ave. Silver Spring																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State) D.C.								
Burial			April 11, 1969			Fort Lincoln Mausoleum			Washington, D. C.								
24. FUNERAL DIRECTOR C. Glen Carter 434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.																	
25a. REC'D BY REGISTRAR APR 11 1969 25b. NOTAR'S SIGNATURE																	

08730

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.



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UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

FOR STATE
HEALTH DEPT.

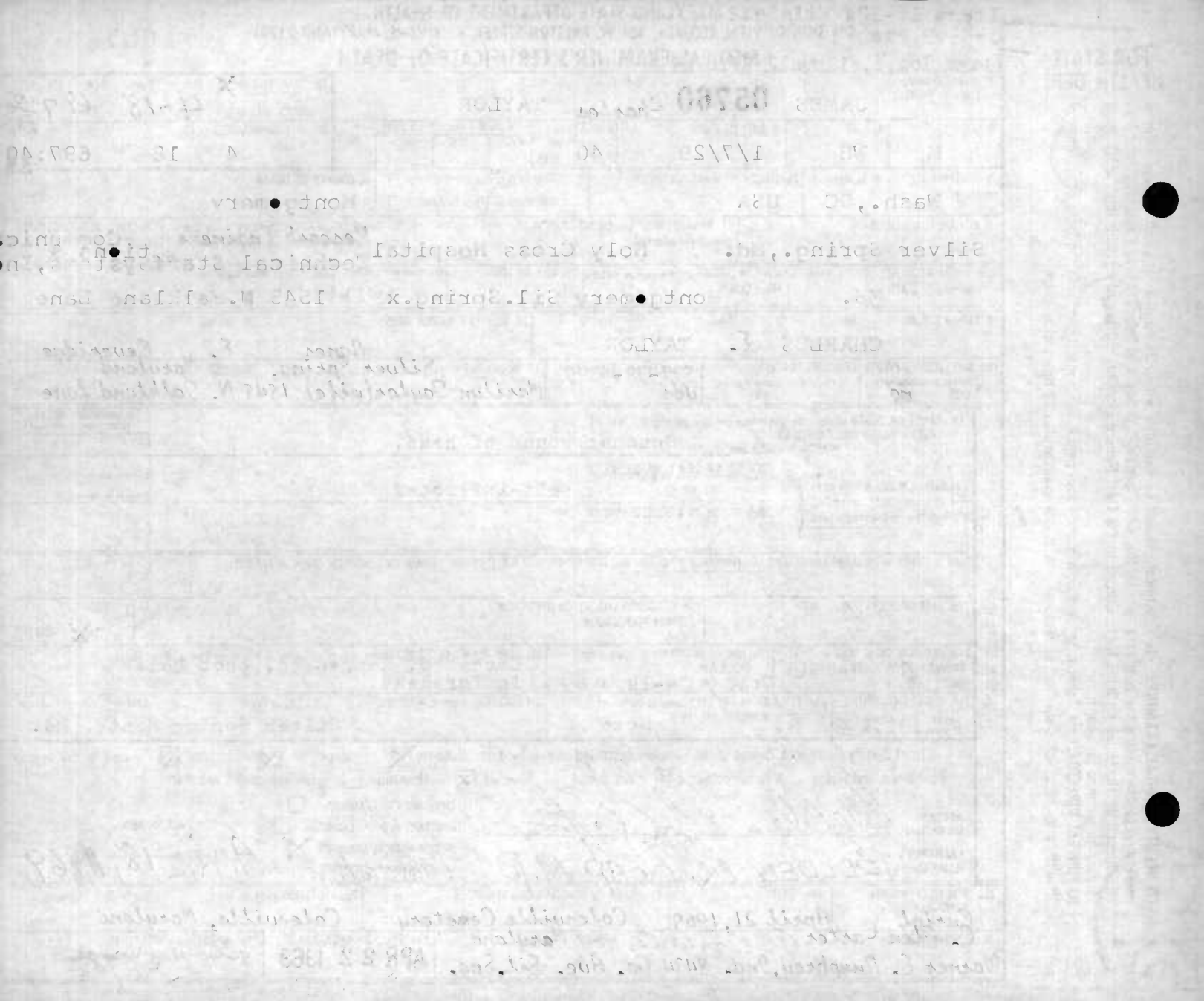
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 412 Maryland State Department of Health
5-8-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 16a, b, Film 412 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05755

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b. HOUR		
JAMES		05760		Charles		TAYLOR		<input checked="" type="checkbox"/>		4	18	1969	7:40		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR	
M	WH	1/7/29		40					4		18	1969	7:40		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH									
Wash., DC		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, or last)				12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring., Md.				Holy Cross Hospital				Research Engineer				Telecommunications & Systems, Inc.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md.				Montgomery		Silver Spring.		NO <input type="checkbox"/>		1545 N. Falkland Lane					
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First	
CHARLES E.				TAYLOR						Agnes E. Beveridge					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				379-5248199		Silver Spring, Maryland		Marilyn Taylor (wife)		1545 N. Falkland Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head,</u> <u>955X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>self-inflicted</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day, Year HOUR A.M. 7:30 P.M. / 4-14 1969					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased, depressed, shot self in forehead.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home					21f. LOCATION Street or R.F.D. No. City or Town County State Silver Spring Montg. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type)					Belden R. Beep M.D.					22b. DATE SIGNED APRIL 18, 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					
Burial					April 21, 1969					Colesville Cemetery					
24. FUNERAL DIRECTOR					Carter Olsen					25a. REC'D BY REGISTRAR DATE					
Warner E. Pumphrey, Inc.					8434 Ga. Ave. Sil. Spg.					APR 22 1969					
25b. REGISTRAR'S SIGNATURE					Charles J. J...										



05761

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARGARET ETTA TAYLOR			2a. DATE OF DEATH Month APRIL Day 12 Year 1969			2b. HOUR 10:15 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 9/27/1886		6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) Utah		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5620 McLean Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 5620 McLean Drive		14. FATHER'S NAME First Middle Last Charles Ellsworth		15. MOTHER'S MAIDEN NAME First Middle Last Isabell Morris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. unknown		17. INFORMANT (daughter) 5609 Wilson Lane Mrs. F. Price Merrels Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Carcinomatosis 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Breast DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Mo 3 YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MARCH , 19 66 , to APRIL 12 , 19 69 , that (I) we last saw the deceased alive on APRIL 11 , 19 69 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we did (did not) view the body after death.							
22b. SIGNATURE Peyton R. Evans, Jr., M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 12, 1969	
22d. PHYSICIAN'S NAME (Type) Peyton R. Evans, Jr., M.D.				22e. ADDRESS 4900 Massachusetts Ave., N. W., Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 4/15/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Washington, D. C.				25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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45. Date notified

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05762		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH		05757				
1. DECEASED NAME (Type or print) <i>Virginia Isabelle Taylor</i>			First Middle Last			2a. DATE OF DEATH Month <i>Apr</i> Day <i>17</i> Year <i>1969</i>			2b. HOUR <i>6:52 A M</i>			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>Aug 11, 1910</i>			6. AGE (in years last birthday) <i>58</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Deerhaven Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY —			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>			13b. COUNTY —		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>6605-32nd St. N.W.</i>			
14. FATHER'S NAME First Middle Last <i>John Mc Carig</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Gertude Smith</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No.</i>			16b. SOCIAL SECURITY NO. —			17. INFORMANT <i>God. Sam. Address</i> <i>Frank Taylor - husband</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis, acute</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary arteriosclerosis, severe</i> DUE TO, OR AS A CONSEQUENCE OF (c) — PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>years.</i>		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>7/11, 1968</i> , to <i>3/28, 1969</i> , that (I) (we) last saw the deceased alive on <i>3/28, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Stephen W. Dejter</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-17-1969</i>				
22d. PHYSICIAN'S NAME (Type) <i>Stephen W. Dejter</i>						22e. ADDRESS <i>6719 Wilcox Lane, Bethesda, Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-21-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery-Arlington County, Virginia</i>				23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, INC.</i>						25a. REC'D BY REGISTRAR DATE <i>APR 23 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>				

TO : DIRECTOR, FBI (100-371100)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

Very truly yours,
[Illegible Signature]

X

100-371100-1000
100-100000-1000
[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23c 05763 Items #5,6,14,17, Film 413 6/2/69		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05758		
1. DECEASED-NAME (Type or print) First Middle Last ESTHER PENELOPE THOMPSON			2a. DATE OF DEATH Month Day Year APRIL 17 1969		2b. HOUR 6:30 PM	
3. SEX FEMALE	4. RACE CAUC	5. DATE OF BIRTH 23 NOVEMBER 1928		6. AGE (In years lost birthday) 40 30 YRS.	IF UNDER 1 YEAR MONTHS DAYS 4 24	IF UNDER 24 HRS. HOURS MIN 4 24
7a. BIRTHPLACE (State or foreign country) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		Md.
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL, BETH, MD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TECHNICIAN-BIO SCI		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY P. Geo.	13c. CITY OR TOWN LANHAM	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9310 ORBIT LANE	
14. FATHER'S NAME First Middle Last JOSEPH A. PROFUTA		15. MOTHER'S MAIDEN NAME First Middle Last MARIE DELROSSO		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO.		17. INFORMANT Profeta		Address S. AZONE PARK		
17. INFORMANT J. PROFUTA		123-11 150th AVE QUEENS N.Y.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE SUBARACHNOID HEMORRHAGE 4309 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 14 APR , 19 69 , to 17 APR , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 17 APRIL , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.						
22b. SIGNATURE Evans Diamond MD		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 18 APRIL 1969
22d. PHYSICIAN'S NAME (Type) EVANS DIAMOND MD		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-22-69	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETARY		23d. LOCATION (City or Town) (County) (State) QUEENS N.Y.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOME		ADDRESS 7557 WISCONSIN AVE. BETH MD.		25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

05263

ESTHER THOMPSON APRIL 17 1969 0:30

RENAME CASE 23 NOVEMBER 1970

NEW YORK 12A MONTGOMERY

WESTERDA NAYAL HOSPITAL WITH N. TACHICARDIA-810 251

NO 2310 GRAFT TUBE LAMAR

JOSEPH PROCTA

NO 11 PROCTA 113-11 1500 AM NEW YORK N.Y.

NEGATIVE SUBCUTANEOUS INJECTION

YES

IN AIR 20 11 AIR 20 20 20

13 APRIL 1969

EVANS DIAMOND MD NAYAL HOSPITAL WESTERDA

NEW YORK

NO 11 113-11 1500 AM NEW YORK N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05764		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05759	
Item 23 Film 412 4/30/69 kk							
1. DECEASED-NAME (Type or print) First Middle Last Clarence Willard Tibbs				2a. DATE OF DEATH Apr Month 17 Day 69 Year		2b. HOUR 6.50 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 24th 1915		6. AGE (In years last birthday) 53 YRS.	
7a. BIRTHPLACE (State or foreign country) Nebo. Va.		7b. CITIZEN OF WHAT COUNTRY? U S A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montg. Md.	
10. CITY OR TOWN OF DEATH Rt 2. Germantown. Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt 2. Germantown. Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) House wife		12b. KIND OF BUSINESS OR INDUSTRY II	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last Henry Cox		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Tibbs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Claud A. Tibbs. Germantown. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10-23, 19 68, to, 19, that (I) (we) last saw the deceased alive on 4-13-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE Milton D. Westberg M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-18-1969	
22d. PHYSICIAN'S NAME (Type) Milton D. Westberg, M.D.				22e. ADDRESS 431 N. Frederick Ave., Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Memorial Haven		23d. LOCATION (City or Town) (County) (State) Frederick Co. Md.	
24. FUNERAL DIRECTOR Ernest C. Gartner				ADDRESS Gaithersburg, Md.		25a. REC'D BY REGISTRAR APR 21 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

02364

RECEIVED BY THE DIRECTOR, FBI, APR 21 1964

TELETYPE UNIT

TO DIRECTOR, FBI (100-388610) FROM NEW YORK (100-100000) 4P

RE NEW YORK TELETYPE TO BUREAU, APRIL TWENTY, LAST.

ADVISE THAT THE FOLLOWING INFORMATION WAS OBTAINED FROM THE NEW YORK OFFICE OF THE DISTRICT ATTORNEY:

ON APRIL TWENTY, LAST, THE NEW YORK OFFICE OF THE DISTRICT ATTORNEY ADVISED THAT THE FOLLOWING INFORMATION WAS OBTAINED FROM THE NEW YORK OFFICE OF THE DISTRICT ATTORNEY:

ON APRIL TWENTY, LAST, THE NEW YORK OFFICE OF THE DISTRICT ATTORNEY ADVISED THAT THE FOLLOWING INFORMATION WAS OBTAINED FROM THE NEW YORK OFFICE OF THE DISTRICT ATTORNEY:

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ON APRIL TWENTY, LAST, THE NEW YORK OFFICE OF THE DISTRICT ATTORNEY ADVISED THAT THE FOLLOWING INFORMATION WAS OBTAINED FROM THE NEW YORK OFFICE OF THE DISTRICT ATTORNEY:

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05765

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05760

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) PHILLIP			First Middle Last TIPPERMAN			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 - 11 - 69 Year 19			2b. HOUR 6:36 AM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12-25-16	6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS 52	DAYS 0	IF UNDER 24 HRS. HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD Month 4 - 11 - 69 Year 19			2d. HOUR 6:36 AM
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5110 Yosemite Dr.		
14. FATHER'S NAME Benjamin Tipperman				15. MOTHER'S MAIDEN NAME Eva Finkelstein							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) No			16b. SOCIAL SECURITY NO.		17. INFORMANT Milton Tipperman, 5110 Yosemite Dr.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to hanging, self-inflicted DUE TO, OR AS A CONSEQUENCE OF: (b) Asphyxiation due to hanging, self-inflicted DUE TO, OR AS A CONSEQUENCE OF: (c) Asphyxiation due to hanging, self-inflicted Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 4-11-69 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased, depressed, hanged self from door frame						
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Blag.			21f. LOCATION (Street or R.F.D. No. City or Town County State) 1055 Ripley St. S.S. Montgomery Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap		22b. DATE SIGNED April 11, 1969									
EXAMINER'S NAME (Type) Belden R. Reap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, county) Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/13/69		23c. NAME OF CEMETERY OR CREMATORY KING DAVID Mem. Garden			23d. LOCATION (City or Town) (County) (State) FALLS CHURCH Va.				
24. FUNERAL DIRECTOR B. Dargansky & Sons, 3501-14th St. WASH. D. C.						25. REC'D BY REGISTER APR 16 1969		26. SIGNATURE [Signature]			

052405

REU M EXAMINE, EASTWALL OF DEIN

APR 18 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (Y4)
30M REV. 1-66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05766									
CERTIFICATE OF DEATH									
05761									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Madeline			Tonelli			April 15 1969			9:20 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		October 17, 1904		64 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. COUNTY OF DEATH	
Italy		U.S.A.						Montgomery Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring			Holy Cross Hospital			house wife			own home
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9509 Midwood Road
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Jerome Simonutti			Anna (unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> no, <input type="checkbox"/> or unknown <input type="checkbox"/>			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
--			079-06-0611		Mr. Peter Tonelli, 9509 Midwood Road, Silver Spring, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INCREASED INTRACRANIAL PRESSURE</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u> <u>1 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-11</u> , 19 <u>69</u> , to <u>4-15</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Francis C. Mayle Jr MD</u>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-16-69</u>
22d. PHYSICIAN'S NAME (Type) <u>FRANCIS C MAYLE JR MD</u>					22e. ADDRESS <u>8218 Wisconsin Ave Bethesda Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 19, 1969		Gate of Heaven Cemetery		Silver Spring, Mont., Md.			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
							APR 22 1969		

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05767		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05762	
Item 23 Film G111 4/14/69 kk					
1. DECEASED-NAME (Type or print) First Middle Last Rebecca Kay Toney			2a. DATE OF DEATH Month Day Year April 5 1969		2b. HOUR 11:25 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 20 July 1963		6. AGE (In years last birthday) 5 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Prince William	13c. CITY OR TOWN Manassas Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 141 Colburne Drive
14. FATHER'S NAME First Middle Last Jack E. Toney		15. MOTHER'S MAIDEN NAME First Middle Last Deanna Meadows			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Bethesda, Md. 20014 The Medical Records, The Clinical Center	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> 204.0 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Systemic Candidiasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Lymphocytic Leukemia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hours 2 weeks 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from <u>1 December 1968</u> , to <u>5 April 1969</u> , that (1) (we) last saw the deceased alive on <u>2 April 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert E. Gallagher, M.D.</u> DEGREE				22c. DATE SIGNED 6 April 1969	
22d. PHYSICIAN'S NAME (Type) Robert E. Gallagher, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 8 69		23c. NAME OF CEMETERY OR CREMATORY Stonewall Memory	
23d. LOCATION (City or Town) Manassas, Virginia.		23e. LOCATION (County) Manassas, Virginia.		23f. LOCATION (State) Manassas, Virginia.	
24. FUNERAL DIRECTOR <u>Baker Funeral Home</u> Manassas, Va.				25a. REG'D BY REGISTRAR APR 10 1969 DATE	
25b. REGISTRAR'S SIGNATURE <u>G. Allen Baker</u>				25c. REGISTRAR'S SIGNATURE <u>G. Allen Baker</u>	

1930 TO 1939

1940 TO 1949

1950 TO 1959

1960 TO 1969

1970 TO 1979

1980 TO 1989

1990 TO 1999

2000 TO 2009

2010 TO 2019

2020 TO 2029

2030 TO 2039

2040 TO 2049

2050 TO 2059

2060 TO 2069

2070 TO 2079

2080 TO 2089

2090 TO 2099

2100 TO 2109

2110 TO 2119

2120 TO 2129

2130 TO 2139

2140 TO 2149

2150 TO 2159

2160 TO 2169

2170 TO 2179

2180 TO 2189

2190 TO 2199

2200 TO 2209

2210 TO 2219

2220 TO 2229

2230 TO 2239

2240 TO 2249

2250 TO 2259

2260 TO 2269

2270 TO 2279

2280 TO 2289

2290 TO 2299

2300 TO 2309

2310 TO 2319

2320 TO 2329

2330 TO 2339

2340 TO 2349

2350 TO 2359

2360 TO 2369

2370 TO 2379

2380 TO 2389

2390 TO 2399

2400 TO 2409

2410 TO 2419

2420 TO 2429

2430 TO 2439

2440 TO 2449

2450 TO 2459

2460 TO 2469

2470 TO 2479

2480 TO 2489

2490 TO 2499

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 1/68
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
05768 CERTIFICATE OF DEATH 05763												
1. DECEASED-NAME (Type or print) William Henry Towns						2a. DATE OF DEATH Month April Day 28 Year 1969			2b. HOUR 9:10 MIN M			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 12 September 1913			6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington, D.C.				13b. COUNTY Washington, D.C.		13c. CITY OR TOWN Washington, D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3907 Illinois Avenue, NW		
14. FATHER'S NAME First William Middle Matthew Last Towns				15. MOTHER'S MAIDEN NAME First Henrietta Middle Last Davis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) NO (If yes give war or dates of service) 2-2				16b. SOCIAL SECURITY NO. 237-03-4087		17. INFORMANT Bethesda, Maryland Address The Medical Records, The Clinical Center,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) 116.0 probable Right Middle Lobe Pneumonia										2 Weeks		
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) Cryptococcosis										2 Weeks		
DUE TO, OR AS A CONSEQUENCE OF												
(c) Sezary Syndrome, and Mycosis Fungoides										4 Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 April , 19 69 , to 28 April , 19 69 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 28 April , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did (do not) view the body after death.												
22b. SIGNATURE Pete. Rosen M.D.						DEGREE 		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 30 April 1969		
22d. PHYSICIAN'S NAME (Type) Peter J. Rosen, M.D.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-2-69		23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery				23d. LOCATION (City or Town) (County) (State) Landover, Md.				
24. FUNERAL DIRECTOR W.W. Chambers		ADDRESS 1400 Chapin St. NW		25a. REC'D BY REGISTRAR W.W. Chambers		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 5 1969				

05780

6

Name		Address		City		State		Zip	
John Doe		123 Main St		New York		NY		10001	
Jane Smith		456 Elm St		Los Angeles		CA		90001	
Bob Johnson		789 Oak St		Chicago		IL		60601	
Alice Brown		101 Pine St		Houston		TX		77001	
David Wilson		202 Maple St		Phoenix		AZ		85001	
Emily Davis		303 Cedar St		San Antonio		TX		78101	
Frank Miller		404 Birch St		Dallas		TX		75201	
Grace Lee		505 Walnut St		San Diego		CA		92101	
Henry King		606 Cherry St		Austin		TX		78701	
Ivy White		707 Elm St		Fort Worth		TX		76101	
Jack Black		808 Oak St		San Jose		CA		95101	
Karen Green		909 Pine St		Jacksonville		FL		32201	
Leo Hall		1010 Maple St		Nashville		TN		37201	
Mia Adams		1111 Cedar St		Portland		OR		97201	
Noah Baker		1212 Birch St		San Francisco		CA		94101	
Olivia Carter		1313 Walnut St		Seattle		WA		98101	
Peter Evans		1414 Cherry St		Denver		CO		80201	
Quinn Foster		1515 Elm St		Boston		MA		02101	
Samuel Gibson		1616 Oak St		Sanкт Petersburg		FL		33701	
Tina Harris		1717 Pine St		Phoenix		AZ		85001	
Uma Ivers		1818 Maple St		San Francisco		CA		94101	
Victor Jones		1919 Cedar St		San Antonio		TX		78101	
Wendy King		2020 Birch St		Dallas		TX		75201	
Xavier Lee		2121 Walnut St		San Diego		CA		92101	
Yara Miller		2222 Cherry St		Austin		TX		78701	
Zoe Nelson		2323 Elm St		Fort Worth		TX		76101	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 7 Film 411 7/1/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05769

CERTIFICATE OF DEATH

05764

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Edythe Margaret Turner						April 28, 1969			6:00pm	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female		White		9-17-92		76 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Minnesota		USA				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park			Washington San & Hospital			Teacher Home Demo			Agent of State Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Mont.		Takoma Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7710 Maple Ave.,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
David H. Turner			Elizabeth - Bohrer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No			031-28-8652		May C. Turner - Address Hospital Records 7710 Maple Ave., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Congestive Failure & Pneumonitis										1 day
4409 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) Arteriosclerosis & Diabetes Mellitus, Gall Stones										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Peripheral Vascular Disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M.								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from 7/1/50, to April 28, 1969, that (I) (we) last saw the deceased alive on April 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						22c. DATE SIGNED				
Chas H. W. L. L. N.						4/28/69				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
						831 Univ. Blvd. E., Silver Spring, Md.				
23a. BURIAL RECORD NO.		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
8434		May 2, 1969		Oakdale Cemetery			Crookston, Minnesota			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Warner E. Pumphrey, Inc. Silver Spring, Md.						MAY 2 1969		James		

05362

STATE OF TEXAS

COUNTY OF DALLAS

April 11, 1905

Prothonotary

County Clerk

Deputy

7

5-77-98

Wm. H. H. H.

Wm. H. H. H.

Mon. 11

11

Wm. H. H. H.

Wm. H. H. H. & Son, Inc.

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7769

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05770

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05765

1. DECEASED-NAME (Type or print) Russell			First Middle Last ULDRICK			2a. DATE OF DEATH Month 22 Day 1969 Year			2b. HOUR 1220AM					
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH Apr. 21, 1969			6. AGE (In years lost birthday) YRS. MONTHS DAYS HOURS MIN. 10					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A			12b. KIND OF BUSINESS OR INDUSTRY N/A					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Kensington			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 10108 Thornwood Road		
14. FATHER'S NAME Thomas			First Middle Last S. Uldrick			15. MOTHER'S MAIDEN NAME Lucille			First Middle Last Brazil					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Kensington, Md. Address Mr. Thomas S. Uldrick, 10108 Thornwood Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 7769 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I (this hospital) attended the deceased from Apr. 21 , 19 69 , to Apr. 22 , 19 69 , that I (we) last saw the deceased alive on Apr. 22 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.														
22b. SIGNATURE Gary H. Safley, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED Apr. 23, 1969					
22d. PHYSICIAN'S NAME (Type) GARY H. SAFLEY, M.D.						22e. ADDRESS Naval Hospital, Bethesda, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-28-69			23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) (County) (State) Arlington Va.					
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Funeral Home 7557 Wisconsin Ave., Bethesda, Md.						25a. REC'D BY REGISTRAR MAY 5 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
05771 CERTIFICATE OF DEATH 05766												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Donna Marie UNDERWOOD						April 27 1969			6:30am			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Caucasian		26 April 1969			YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland-AA		USA					Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Naval Hospital			N/A			N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
STATE Maryland			13b. COUNTY Montgomery			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13009 Wilton Oaks Drive				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
DEWEY L. UNDERWOOD			BARBARA MARIE THOMPSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT						
No			None			Father: 13009 Wilton Oaks Drive Silver Spring, Md. 20902						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Neonatal Hepatitis with Hydrencephaly												
0795												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF Cytomegalic Inclusion disease												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State		
22a. I certify that (X) (this hospital) attended the deceased from 26 April, 19 69, to 27 April, 19 69, that (X) (we) last saw the deceased alive on 27 April, 19 69, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
G. H. SAFLEY										28 April 1969		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
LT MC USN						NAVAL HOSPITAL, BETHESDA, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		May 1, 1969		Arlington National Cem.		Arlington		Virginia				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
W. E. PUMPHREY FUNERAL HOME, 8434 Georgia Ave., Silver Spring, Md.						MAY 5 1969		Charles Judge				

1750.

24 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05772		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05767			
1. DECEASED-NAME (Type or print) First Robert Middle G. Last VanVranken						2a. DATE OF DEATH Month April Day 20 Year 69		2b. HOUR 1:55 M P	
3. SEX M		4. RACE Can		5. DATE OF BIRTH 5/1/98		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) State Est. etc		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7601 Quintana Ct.	
14. FATHER'S NAME First Fred Middle VanVranken Last VanVranken		15. MOTHER'S MAIDEN NAME First Elizabeth Middle Adam Last Adam							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 277-10-7039		17. INFORMANT Margaret VanVranken Address same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. COLO (b) PRIMARY CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) COLO APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTH 3-4 MONTH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 1/15/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA COLO		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 19 Day 19 Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 5214 WISCONSIN AVE City or Town BETHESDA County Prince Georges State MD					
22a. I certify that (I) (this hospital) attended the deceased from JAN , 19 57 , to 4/1 , 19 69 , that (I) (we) last saw the deceased alive on APRIL 19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DR LEO I DONOVAN		DEGREE DR		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/20/69			
22d. PHYSICIAN'S NAME (Type) DR LEO I DONOVAN		22e. ADDRESS 5214 WISCONSIN AVE BETHESDA							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 4-21-1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) Suitland (County) Prince Georges (State) MD			
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC ADDRESS 5190 WISC. AVE., N. W. WASH., D. C. 20016				25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

05772

Verfahren

G.

Robert

Operation 1-1-1939
Cotton Hill Property
Salem, Prince Georges Co. Md.

1939

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05773

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05768

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
John			William	Vernon	April 11 1969			5:50 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		June 23, 1909		59 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
District of Col.		America				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington San Hosp.			House Painter					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Montgomery		Rockville	YES		16530 Emory Lane			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John					Vernon	Lula					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes			WWII			Grace H. Riley			Rockville, Md.		
			578-26-3009			XXXXXXXX			16530 Emory Lane		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebral Vascular Accident										5 1/2 days	
4329 DUE TO, OR AS A CONSEQUENCE OF											
(b) Thrombosis of left internal carotid artery										5 1/2 days	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8/4, 1965, to April 11, 1969, that (I) (we) last saw the deceased alive on April 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
Philip E. Jones M.D.									4/11/69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Philip E. Jones MD						800 Pershing Drive Silver Spring, Md 20910					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			April 14, 1969			Washington National Cem			Suitland, Maryland		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Md.						APR 17 1969			W. Charles Judge		

02778

0001-00-002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05774		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05769	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) BERTHA First L. Middle Waldron Last XXXXXX				2a. DATE OF DEATH 4 Month 13 Day 69 Year		2b. HOUR 9:30 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH April 11, 1875		6. AGE (In years last birthday) 94 YRS.	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH Burtonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3408 Greencastle Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Burtonsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3408 Greencastle Road							
14. FATHER'S NAME First August Middle Erdmann Last Erdmann		15. MOTHER'S MAIDEN NAME First Henriette Middle Erdmann Last Erdmann					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-44-8097		17. INFORMANT MARY L. CUNNINGHAM Address 910 Halburn St. 55 W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 1967 to April 13, 1969 , that (I) (was) lost saw the deceased alive on March 21, 1969 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.							
22b. SIGNATURE Burton A. Johnson, M.D. DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4-13-69			
22d. PHYSICIAN'S NAME (Type) Burton A. Johnson				22e. ADDRESS 4140 Sandy Springs Rd, Burtonsville.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 16, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Md.				25a. REC'D BY REGISTRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

100-100000

STATE OF TEXAS

COUNTY OF DALLAS



Know all men by these presents, that

JOHN A. SMITH, of the County of Dallas, State of Texas, for and in consideration of the sum of

the sum of

Five hundred and no/100 Dollars, to him in hand paid by

JOHN A. SMITH, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said

JOHN A. SMITH, his heirs and assigns forever, all that certain

tract of land, situate in the County of Dallas, State of Texas, containing

more or less, as the same may hereafter appear of record in the public records of the County of Dallas, State of Texas, to-wit:

Tract of land, situate in the County of Dallas, State of Texas, containing

more or less, as the same may hereafter appear of record in the public records of the County of Dallas, State of Texas, to-wit:

Tract of land, situate in the County of Dallas, State of Texas, containing

JOHN A. SMITH

JOHN A. SMITH

Witness my hand and seal of office, this

day of

Notary Public in and for the State of Texas

My commission expires

Notary Public in and for the State of Texas

My commission expires

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 M
30M REV. 1/78

05775		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05770				
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First VIVIAN		Middle S.	Last WALSH	2a. DATE OF DEATH 4 Month 3 Day 69 Year		2b. HOUR M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12/22/17		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) NEB.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.		13b. CITY OR TOWN Beltsville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3129 Fallston Ave				
14. FATHER'S NAME First Same		Middle Sander		Last Eva		15. MOTHER'S MAIDEN NAME First Spukerman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. Yes		17. INFORMANT John J. Walsh		3129 Fallston Avenue Beltsville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u> 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma of Duodenum</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>14 mos</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several mos		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Thrombocytopenia</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>2/28, 1968</u> , to <u>4/3, 1969</u> , that (I) (we) last saw the deceased alive on <u>4/3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>G. Lennard Gold</u>		DEGREE G. Lennard Gold		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/4/69
22d. PHYSICIAN'S NAME (Type) G. Lennard Gold		22e. ADDRESS 9801 Georgia Avenue, Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE April 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Prince Georges County, Md.				
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		ADDRESS Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE <u>Richard J. [Signature]</u>				

07520

1994-1995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>05776</div> <div>CERTIFICATE OF DEATH</div> <div>05771</div>									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Charles Allen Walters						April 14, 1969			11:29
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White		3 January 1928			41 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.
North Carolina	U.S.A.					Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			The Clinical Center, NIH			Carpenter			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
North Carolina			13b. COUNTY			Hope Mills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Route 1
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Barney Walters			Maude Maggs						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			242-40-2126			The Medical Record The Clinical Center, NIH, Bethesda, Md, 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>									2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disseminated Malignant Melanoma</u>									3 years
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from <u>12 April, 1969</u> , to <u>14 April, 1969</u> , that (X) (we) lost saw the deceased alive on <u>14 April, 1969</u> , and that in (X) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Everett V. Sugarbaker, M.D.</i>					22c. DATE SIGNED 15 April 1969				
22d. PHYSICIAN'S NAME (Type) Everett V. Sugarbaker, M.D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda Md. 20014				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		4-19-69				RED SPRINGS, N.C.			
24. FUNERAL DIRECTOR W.W. Chambers Co					24b. ADDRESS 1400 Chapin St NW		24c. REG'D BY REGISTRAR APR 23 1969		24d. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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Results

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4. 4. 4.

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

• 66 •

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2. *Microtus pennsylvanicus* (Cope) 3. *Peromyscus maniculatus* (Cope)

2254-2255

1994

SECRET

...continued ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

05777

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05772

1. DECEASED-NAME (Type or print) Andre' David Walther			2a. DATE OF DEATH Month April Day 23 Year 1969			2b. HOUR P 5:20 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 20 August 1960		6. AGE (In years last birthday) 8 YRS.	
7a. BIRTHPLACE (State or foreign country) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Iowa		13b. COUNTY Cedar Falls		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1809 West Ridgewood Drive	
14. FATHER'S NAME First Andre' Middle Gaston Last Walther			15. MOTHER'S MAIDEN NAME First Wyatte Middle Thompson Last Thompson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burkitt's Lymphoma 2022 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1 April , 19 69 , to 23 April , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 23 April , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.							
22b. SIGNATURE Sherrard L. Hayes, MD		22c. DATE SIGNED 24 April 1969		22d. PHYSICIAN'S NAME (Type) Sherrard L. Hayes, MD.			
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014		22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-21-69		23c. NAME OF CEMETERY OR CREMATORY SOULAC CEMETERY		23d. LOCATION (City or Town) (County) (State) GIRONDE FRANCE	
24. FUNERAL DIRECTOR W.W. Chambers Co		ADDRESS 8655 GA AVE		25a. REC'D BY REGISTRAR MAY 1 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05778

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05773

1. DECEASED-NAME (Type or print) First Middle Last Alec Robert WATSON			2a. DATE OF DEATH Month Day Year April 9, 1969		2b. HOUR 8:45 P.M.	
3. SEX Male		4. RACE CAUCASIAN		5. DATE OF BIRTH April 9, 1969		
6. AGE (In years lost birthday) YRS.		7. AGE (In years lost birthday) MONTHS		8. AGE (In years lost birthday) DAYS		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. COUNTY OF DEATH Montgomery, Md.		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		
12a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		12b. COUNTY A. Arundel		12c. CITY OR TOWN Crofton		
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET AND NUMBER 1704 Spring Green Rd.		13c. KIND OF BUSINESS OR INDUSTRY		
14. FATHER'S NAME First Middle Last James W. WATSON		15. MOTHER'S MAIDEN NAME First Middle Last Mary Jean Sweeney		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes, no, or unknown		
17a. SOCIAL SECURITY NO. 7769		17b. DATE OF DEATH 4/12/69		17c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Failure to Expand lungs DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Low lying Placenta, Cord around neck		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		20c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. LOCATION Street or R.F.D. No. City or Town County State		
21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) at work		21e. LOCATION Street or R.F.D. No. City or Town County State		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Donald Levitt		22c. DATE SIGNED 4/19/69		
22d. PHYSICIAN'S NAME (Type) Donald Levitt M.D.		22e. ADDRESS 3233 Superior Ave. Bowie, Md.		22f. ADDRESS 3233 Superior Ave. Bowie, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/12/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		
23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.		23e. LOCATION (City or Town) (County) (State) Silver Spring, Md.		23f. LOCATION (City or Town) (County) (State) Silver Spring, Md.		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rock. Pike		24a. ADDRESS Rockville, Maryland		24b. REC'D BY REGISTRAR APR 15 1969		
24c. REGISTRAR'S SIGNATURE O. Charles Under		24d. REGISTRAR'S SIGNATURE O. Charles Under		24e. REGISTRAR'S SIGNATURE O. Charles Under		

05773

Alce Robert

A. Amstel Grafton

1916

1704 Spring Court St

Survey 11111

James A. Amstel

Failure to Expand July 2

Long Hump Mountain, Old summit track

4

Amstel Grafton

X

4/19/19

Donald Keith

3333

Superior Air Service

Alce Robert

1916

05773

Long Hump Mountain, Old summit track

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Office Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 412 MARYLAND STATE DEPARTMENT OF HEALTH
5-12-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05774

1. DECEASED-NAME (Type or Print) <i>Charles W. Wheeler Weaver</i>			2a. DATE KNOWN <input type="checkbox"/> Month Day Year <i>4 12 1969</i>			2b. HOUR <i>11:30</i> M		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Nov 6 1954</i>	6. AGE (In years last birthday) <i>14</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <i>April 12</i> Month Day Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Wash DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Shubert Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Student</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Ch. Ch.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>6922 Woodside Pl.</i>
14. FATHER'S NAME First Middle Last <i>Charles L. Weaver</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Margaret Lomas</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Father - Charles Weaver</i>		ADDRESS <i>Line as 13e</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>17-1-1-1-1-1-1 Encephalitis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Viral infection</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.?</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pneumonitis - Viral</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>April 13, 1969</i>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		(Street, City, Town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>4/14/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince George's County Md.</i>		
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home 1391 Rock Pike Rockville, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>APR 15 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

02778 MEDICAL CASE NO. 123456789



1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A15 (4)
45M - 1/69

05780		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
Item #6, Film G411 4/18/69 km		CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) First Middle Last NYLA C. WEBB		20. DATE OF DEATH Month Day Year APRIL 9 1969	
3. SEX FEMALE		2b. HOUR a 0140 M	
4. RACE CAUC		5. DATE OF BIRTH 05 SEPT 1913	
6. AGE (In years last birthday) 55 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS 6 8	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania		13b. CITY OR TOWN Selins Grove	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER Hoover's Trailer Park	
14. FATHER'S NAME First Middle Last Unknown		15. MOTHER'S MAIDEN NAME First Middle Last Hazel Putt	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 224-28-9168	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma breast with metastases 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) at work <input type="checkbox"/> at home <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from 31 MAR, 19 69, to 9 APR, 19 69, that (X) (we) last saw the deceased alive on 9 APRIL 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.			
22b. SIGNATURE M. D. GORMAN M. D.		22c. DATE SIGNED 9 April 1969	
22d. PHYSICIAN'S NAME (Type) M. D. GORMAN M. D.		22e. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Type) Buried		23b. DATE 4-11-69	
23c. NAME OF CEMETERY OR CREMATORY Westside Cemetery		23d. LOCATION (City or Town) (County) (State) Selins Grove Penn.	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR APR 15 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05781

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05776

1. DECEASED-NAME (Type or print) First Middle Last Mabel Elizabeth Webster			2a. DATE OF DEATH Month 4 Day 8 Year 69			2b. HOUR 10 AM		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 8/9/1892		6. AGE (In years lost birthday) 76 YRS.		
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Wheaton, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nurs. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington, DC			13b. COUNTY ✓		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1811 Vernon St., NW	
14. FATHER'S NAME First Middle Last Marshall Wanser			15. MOTHER'S MAIDEN NAME First Middle Last Martha Foultz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. 578-66-6001		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 1968</u> , to <u>APRIL 1969</u> , that (I) (we) saw the deceased alive on <u>2 APR 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Walter Goozh, M.D.</u> M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8 April 69		
22d. PHYSICIAN'S NAME (Type) Walter Goozh, M.D.				22e. ADDRESS 2309 Shorefield Rd., Wheaton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/12/1969		23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City or Town) (County) (State) Catlett, Virginia		
24. FUNERAL DIRECTOR <u>W.C. Jarvis & 1432 You N.W.</u>				25a. REC'D BY REGISTRAR DATE APR 14 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

00781

STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
SAM WEINER						April 3, 1969		9:00p M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Male		White		May 15, 1886		82		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Russia		USA				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Wash. San. & Hosp.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Mont.		SilverSpring				518 Lamberton Dr.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Max Weiner			Judith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
None			076-28-3169-A		Mr. Max Weiner, as above		Son			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) CVA										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF										
(b) (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION					
While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 1968, to Apr 3, 1969, that (I) (we) last saw the deceased alive on Apr 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)					
R.H. Sandstrom MD		4/3/69			R.H. Sandstrom MD					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			22f. REC'D BY REGISTRAR					
R.H. Sandstrom MD		7701 Carroll Ave Takoma Park, Md			APR 7 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REG'D BY REGISTRAR		
BURIAL		April 6, 1969		Beth David Cemetery		Elmont, New York		23f. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR		Donald M. Stein		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				232 Carroll St., N.W. Wash., D.C.		APR 7 1969		Hebrew Memorial Funeral Home		

05782

STATION 11, 1000 YARDS, 1000 YARDS, 1000 YARDS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

05783		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05778			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <u>Llewellyn Hopkins Welsh</u>			First Middle Last			2a. DATE OF DEATH Month <u>APRIL</u> Day <u>26</u> Year <u>1969</u>		2b. HOUR <u>6:15</u> A.M.	
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>Nov. 1, 1912</u>		6. AGE (In years last birthday) <u>56</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.			
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>SUBURBAN HOS. P.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Research Chemist</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Food + Drug</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>6302 Valley Road</u>	
14. FATHER'S NAME First <u>Abner H.</u> Middle <u>Welsh</u> Last <u>Welsh</u>			15. MOTHER'S MAIDEN NAME First <u>Rose</u> Middle <u>Greer</u> Last <u>Greer</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>215-44-8363</u>		17. INFORMANT <u>Wife - Betty D. Above</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insuff</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arterio sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>February, 1968</u> , to <u>4-26, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 26, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen W. DeJeter, M.D.</u>		DEGREE <u>M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-26-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>STEPHEN W. DEJETER, M.D.</u>		22e. ADDRESS <u>6719 WILSON LANE BETHESDA, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-29-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE, MD.</u>			
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS</u>		ADDRESS <u>5130 WIS. AVE. NW</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

02583

CERTIFICATE OF DEATH

SECTION OF VITAL RECORDS AND VITAL STATISTICS DIVISION

1914

[Faint, illegible text, likely a death certificate form with fields for name, date, and location.]

4/23
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05784		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05779	
1. DECEASED-NAME (Type or print)		First Sam	Middle Bud	Lost Werner	20. DATE OF DEATH Month Day Year April 30 1969		2b. HOUR 5:05 M
3. SEX Male	4. RACE White		5. DATE OF BIRTH 11 August 1934		6. AGE (In years last birthday) 34 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Newspaperman		12b. KIND OF BUSINESS OR INDUSTRY Newspaper	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Arlington		13c. CITY OR TOWN Arlington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 111 North Edgewood Street	
14. FATHER'S NAME First Middle Lost Eugene A. Werner		15. MOTHER'S MAIDEN NAME First Middle Lost Lillian Band					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 1958		17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> 4/23 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Postoperative myocardial revascularization</u> DUE TO, OR AS A CONSEQUENCE OF <u>ventricular scarring</u> (c) <u>Severe coronary artery disease and left</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 12 hours 7 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 27 April, 1969, to 30 April, 1969, that (X) (we) last saw the deceased alive on 30 April, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (did not) view the body after death.							
22b. SIGNATURE Bradley M. Rodgers				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 30 April 1969	
22d. PHYSICIAN'S NAME (Type) Bradley M. Rodgers, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-1-1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION (City or Town) (County) (State) Iselin New Jersey	
24. FUNERAL DIRECTOR ADDRESS Goldberg Funeral Home 4217 9th Street N.W.				25a. REC'D BY REGISTRAR DATE MAY 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05785		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05780			
Items 5 & 6 Film 412 5/9/69 kk		CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <u>Kathleen FRENCH</u>			First Middle Last <u>White</u>			2a. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>69</u>		2b. HOUR <u>8 PM</u>	
3. SEX <u>F</u>		4. RACE <u>Cau.</u>		5. DATE OF BIRTH <u>3-4-1875</u>		6. AGE (In years last birthday) <u>94</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Ireland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u>			
10. CITY OR TOWN OF DEATH <u>Kensington</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Kensington Gardens</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Mont</u>		13c. CITY OR TOWN <u>Chevy Chase</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>3351 Jones Bridge Rd.</u>	
14. FATHER'S NAME First Middle Last <u>Thomas FRENCH</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>CATHERINE FORBES</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>no</u>		16b. SOCIAL SECURITY NO. <u>579 20 6769</u>		17. INFORMANT <u>MRS. MAURICE KEANE</u> Address <u>5234 BALTIMORE AVE.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>Generalized arteriosclerosis</u>									
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/24, 1968</u> , to <u>4/22, 1969</u> , that (I) (we) last saw the deceased alive on <u>4/22, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John B. Umhau MD</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/24/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU</u>					22e. ADDRESS <u>8805 Conn. Ave. Chevy Chase, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 28, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington VIRGINIA</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawlers Sons</u>				ADDRESS <u>5730 WISSE AVE NW DC</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Mrs. Charlotte S. Wigham</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>18</i> Year <i>1969</i>			2b. HOUR <i>11:05 AM</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>Aug 15 1886</i>		6. AGE (In years last birthday) <i>82</i> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____	
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>American</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hospital Washington San</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Practical Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>780 Fairview Ave, Takoma Park</i>	
14. FATHER'S NAME First <i>Rankin</i> Middle _____ Last <i>McMonall</i>			15. MOTHER'S MAIDEN NAME First _____ Middle _____ Last <i>Park</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>172 163 401 A</i>		17. INFORMANT <i>Robert R. Wigham</i>		Address <i>Same as pt.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450X CAROTID ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ANOXIA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>PULMONARY EMBOLUS</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minute</i> <i>minutes</i> <i>days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diabetes</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ at work _____		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____				
22a. I certify that (I) (this hospital) attended the deceased from <i>2-16</i> , 19 <i>69</i> , to <i>2-18</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2-18</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John L. Ford</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-18-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>JOHN L. FORD, M.D.</i>					22e. ADDRESS <i>831 UNIVERSITY BLVD E SILVER SPRING MD.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-23-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Presbyterian Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Pt. Matilda, Pa</i>			
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>					ADDRESS <i>Wash DC</i>		25a. REC'D BY REGISTRAR <i>APR 22 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. [unclear]</i>
26. ADDRESS <i>Simmons Bros 1661-Good Hope Rd SE</i>									

02/03

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CLEARED BY DR. REAP

FOR STATE HEALTH DEPT.

05787

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05782

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Byron Hilton Wildermuth			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 4/4/69 8:55 PM	
3. SEX male	4. RACE white	5. DATE OF BIRTH 7/30/95	6. AGE (in years) 73 YRS.	7c. DATE PRONOUNCED DEAD Month 4 Day 4 Year 69
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanical Eng.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME Frederick Albert		15. MOTHER'S MAIDEN NAME Mary E. Snyder		13e. STREET AND NUMBER 304 Hamilton Avenue
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWI		16b. SOCIAL SECURITY NO. 164 09 7179 N	17. INFORMANT Mrs. Catharine Wildermuth	
ADDRESS 304 Hamilton Ave Sil Sp Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED April 5, 1969
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (City, town, or county) Rockville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 8, 1969	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR Warner E. Plomsted, Inc.		ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR APR 10 1969
				25b. REGISTRAR'S SIGNATURE William H. Judge

0278

FOR THE
GATEWAY

NAME	LAST	FIRST	MIDDLE	SUFFIX
SMITH	JOHN	DAVID	WILLIAM	JR
DATE OF BIRTH	1925	03	15	
PLACE OF BIRTH	NEW YORK	CITY	STATE	NEW YORK
EDUCATION	HIGH SCHOOL	DIPLOMA	DEGREE	
EMPLOYMENT	MANUFACTURING	INDUSTRY	POSITION	WORKER
RESIDENCE	123	STREET	CITY	STATE
TELEPHONE	555	1234	5678	
MARRIAGE	DATE	PLACE	NAME	
CHILDREN	NAME	DATE OF BIRTH		
RELIGION	PROTESTANT			
POLITICAL PARTY	DEMOCRATIC			
ARMED SERVICES	ARMY	1945	1948	
REMARKS	ALL INFORMATION ON THIS CARD IS UNCLASSIFIED			
DATE OF LAST UPDATE	2000	01	01	
BY	JOHN	DAVID	WILLIAM	JR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05788

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05783

1. DECEASED-NAME (Type or print) First Middle Last Baby Boy Willard			2a. DATE OF DEATH Month Day Year April 4, 1969		2b. HOUR 3:37 M
3. SEX MALE	4. RACE White	5. DATE OF BIRTH 4-4-69		6. AGE (In years last birthday) — YRS.	IF UNDER 1 YEAR MONTHS DAYS 1
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San & Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Mont.	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 636 Houston Ave., Apt 401	
14. FATHER'S NAME First Middle Last Robert Edward Willard		15. MOTHER'S MAIDEN NAME First Middle Last Patricia Ann Williamson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT Address Mother		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal asphyxia 771.1 DUE TO, OR AS A CONSEQUENCE OF (b) Prolapsed cord DUE TO, OR AS A CONSEQUENCE OF (c) Premature, Breech presentation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No.	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. B. Beardsley, M.D.		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4-4-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 4-5-69	23c. NAME OF CEMETERY OR CREMATORY Wash., San & Hospital		23d. LOCATION (City or Town) (County) (State) Takoma Park, Mont., Md.	
24. FUNERAL DIRECTOR J. D. Ruffcorn, Takoma Park, Maryland		25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

28720

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— 225 —

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05789

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05784

1. DECEASED NAME (Type or Print) Bertie V. Williams			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 Day 3 Year 1969			2b. HOUR 1:25 AM	
3. SEX F	4. RACE W	5. DATE OF BIRTH July 18, 1896	6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month 4 Day 3 Year 1969	
7a. BIRTHPLACE (State or foreign country) Wash. D. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Adm. National Geographic Society		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME First Albert Middle M. Last Williams		15. MOTHER'S MAIDEN NAME First Laura Middle U. Last Welsh		13e. STREET AND NUMBER 8712 Colesville Rd. #205		13f. ADDRESS 8712 Colesville Rd. Silver Spring, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 579-48-8282		17. INFORMANT Mrs. Estelle Nicholson		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Artery Heart Disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED APRIL 3, 1969	
EXAMINER'S NAME (Type) BELDEN R. REAP		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (City, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 5, 1969		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR P. J. Smith Warner & Pumphrey, Inc.		8434 ADDRESS Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

03280

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		JEROME OLIVER Middle		WILLIAMS Lost		2a. DATE KNOWN OF DEATH		Month 4 Day 10 Year 69		2b. HOUR		2:30P M			
3. SEX		M		4. RACE		W		5. DATE OF BIRTH		4-13-11		6. AGE (In years lost birthday)		58 YRS	
7a. BIRTHPLACE (State or foreign country)		Not known		7b. CITIZEN OF WHAT COUNTRY?		Not known		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Montgomery Md.	
10. CITY OR TOWN OF DEATH		Takoma Pk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		Washington San & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		Maryland		13b. COUNTY		Montgomery		13c. CITY OR TOWN		Takoma Pk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 64 Walnut Ave	
14. FATHER'S NAME		First		Middle		Lost		15. MOTHER'S MAIDEN NAME		First		Middle		Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT		Mrs CECIL MURRAY SISTER PER DET. DA LPRYMPLE		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Pneumonitis, rt. lung;															
DUE TO, OR AS A CONSEQUENCE OF															
(b) Fatty metamorphosis of liver, extensive															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				Belden R. Keap M.D.				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				BELDEN R. KEAP, M.D.				APRIL 10, 1969							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY							
				4-29-69				Volunt. Med. School							
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR							
								25b. REGISTRAR'S SIGNATURE							
								DATE MAY 1 1969							

02740

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05791		CERTIFICATE OF DEATH						05786	
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
William Valentine Wilson						Month Day Year April 13 1969			9 ⁴⁵ P M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
M.	Caucasian		10-20-90			78 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Va.		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Rockville			Potomac Valley Nursing Home			Engineer			U.S. Govt.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
md.			mont.		Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		206 Upton St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Clairborne A. Wilson			First Middle Last Maude Glasgow						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes 1917-1919			220-44-6349		Maude Betts		Rockville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Uremia									1 month
185X DUE TO, OR AS A CONSEQUENCE OF									
(b) Carcinoma of prostate									9 months
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Arteriosclerotic cardiovascular disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept 27, 1968, to April 13, 1969, that (I) (we) last saw the deceased alive on April 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Stephen C. Cramwell, MD							April 13, 1969		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Stephen C. Cramwell, MD					615 W. Montgomery Ave, Rockville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-16-69		Arlington, National		Arlington Virginia			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert A Pumphrey					7557 Wisconsin Ave Bethesda, Md		APR 21 1969		
					Charles Judge				

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27

COLLIER

10/10/10



THE NATIONAL ARCHIVES

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NATIONAL ARCHIVES
COLLIER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05792

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05787

1. DECEASED-NAME (Type or print) Lucia Charlotte Windle			2a. DATE OF DEATH Month April Day 22 Year 1969			2b. HOUR 11:40 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH December 20, 1885		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2808 Hardy avenue			
14. FATHER'S NAME First John Wesley Middle Adams Last Adams			15. MOTHER'S MAIDEN NAME First Ellen Middle A. Last Lake						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 183-01-1215-B		17. INFORMANT Mrs. Norton Spence Address Wheaton, Md. 2808 Hardy Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Isa								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of Endometrium with metastases									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-20-1969 , to 4-22-1969 , that (I) (we) lost saw the deceased alive on 4-21-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Boris Rabin, MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-22-69	
22d. PHYSICIAN'S NAME (Type) BORIS RABIN, MD				22e. ADDRESS 1019 Univ Blvd, Cat 55.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Apr. 24, 1969		23c. NAME OF CEMETERY OR CREMATORY Forest Hills Cemetery		23d. LOCATION (City or Town) (County) (State) Philadelphia, Pennsylvania			
24. FUNERAL DIRECTOR C. Glen Carter				ADDRESS 434 Georgia Avenue		25a. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE [Signature]	
Warner E. Pumphrey, Inc. Silver Spring, Md.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05793

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05788

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
ALICE			DOROTHEA			WOOL			Month 4 Day 11 Year 69 4:45 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		CAUC		15 MARCH 1918			51 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
MASS.		USA				MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA			NAVAL HOSPITAL			FSO-3 STATE DEPT.			U.S. Gov't.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
DISTRICT OF COLUMBIA			WASHINGTON			2301 "E" ST. N. W.						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
UNK			WOOL			ALICE			UNK SMULLEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
NO			011 16 0531			MARTHA CLAYPOOL 2039 ROCKINGHAM, MCLEAN, VA.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) CARCENOMA OF THE BREAST WITH WIDE SPREAD METASTASES												
DUE TO, OR AS A CONSEQUENCE OF												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (this hospital) attended the deceased from 25 FEB. 1969, to 11 APR. 1969, that (we) last saw the deceased alive on 11 APR. 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED									
DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			12 APRIL 1969									
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
LT. S. F. DOVI JR., MC, USN			NAVAL HOSPITAL, BETHESDA, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL			14 APRIL 69			MT. OLIVET CEMETERY			Washington, D. C.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Joseph Gawler's Sons, Inc., Washington, D. C.			APR 15 1969			Charles Judge						

02730

RECEIVED
JAN 11 1964

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 1/10/64

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

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26. [Illegible]

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30. [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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05794

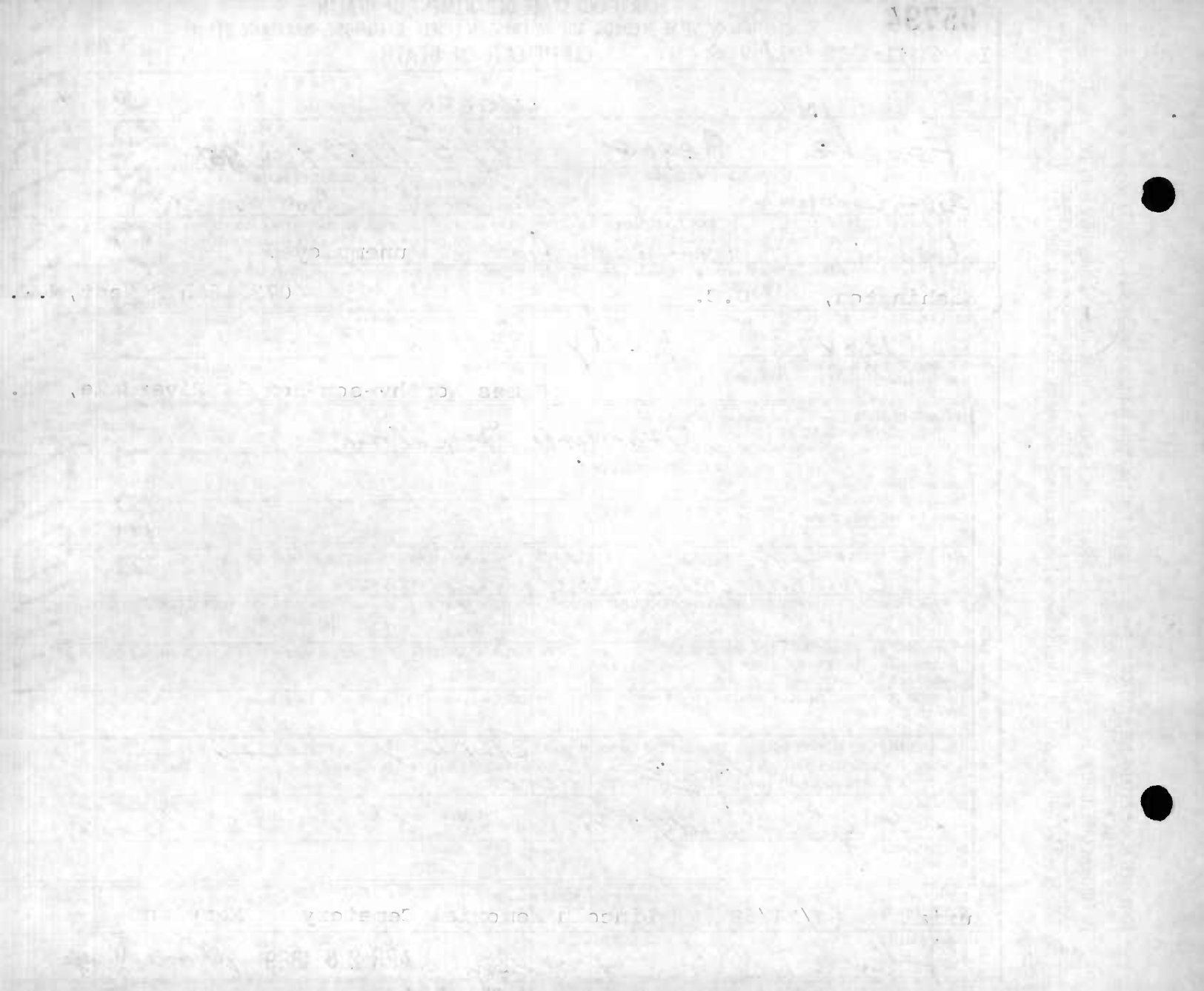
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film Q12 5/1/69 kk

CERTIFICATE OF DEATH

05789

1. DECEASED NAME (Type or print) First Middle Last Worthy, Viola Worthy		2a. DATE OF DEATH Month Day Year 4 21 69		2b. HOUR 10:30 M.
3. SEX FEMALE	4. RACE Negro	5. DATE OF BIRTH 8/5/1884	6. AGE (In years lost birthday) 84 95 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) South Carolina	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nsg. Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) unemployed	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington, D.C.	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4072 16th Street, N.W.	
14. FATHER'S NAME First Middle Last David Kelly	15. MOTHER'S MAIDEN NAME First Middle Last Ellen Farr	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO.		17. INFORMANT Address James Worthy-son-Box 34 Riverdale, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma 203X DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic urinary tract infection				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 3/27/69, 19 to 4/22/69, 19, that (I) (we) last saw the deceased alive on 4/15/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE George C. Arrington		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/22/69
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/24/69	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery	23d. LOCATION (City or Town) Maryland	(County) (State)
24. FUNERAL DIRECTOR John J. Stewart		ADDRESS 4001 Benson	25a. REC'D BY REGISTRAR APR 28 1969	25b. REGISTRAR'S SIGNATURE Charles Judge



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05795

05790

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Shirley Anne Yeatman			2a. DATE OF DEATH Month April Day 23 Year 1969			2b. HOUR 6:50 P				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 17 July 1934		6. AGE (In years last birthday) 34 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania			13b. COUNTY West Grove		13c. CITY OR TOWN West Grove		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 99, R.D. #2	
14. FATHER'S NAME First John Middle D. Last Boggs			15. MOTHER'S MAIDEN NAME First Beatrice Middle Baldwin Last Baldwin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia (bilateral) 2051 DUE TO, OR AS A CONSEQUENCE OF Hepatomegaly, Splenomegaly, massive with focal infarcts Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myelogenous Leukemia (c) Chronic Myelogenous Leukemia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Months-Years 17 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 20 February 1969 , to 23 April 1969 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 23 April 1969 , and that in MD (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.										
22b. SIGNATURE Paul P. Carbone MD DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 24 April 1969			
22d. PHYSICIAN'S NAME (Type) Paul P. Carbone, M. D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-27-69		23c. NAME OF CEMETERY OR CREMATORY London Grove Friends		23d. LOCATION (City or Town) (County) (State) Chester London City Pa				
24. FUNERAL DIRECTOR NAME Robert A Pumphrey ADDRESS 7557 Wisconsin Ave Bethesda, Md					25a. REC'D BY REGISTRAR DATE MAY 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

3220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05796		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05791			
1. DECEASED-NAME (Type or print) First Middle Last BERTHA O. YOUNG						2a. DATE OF DEATH Month Day Year April 17, 1969		2b. HOUR A.M. 11:30	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH Aug. 23, 1882		6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda-Silver Springs Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5435 Alta Vista Road	
14. FATHER'S NAME First Middle Last Joseph Oliver				15. MOTHER'S MAIDEN NAME First Middle Last Abigail Wilkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 577-12-6280B		17. INFORMANT Husband Ford E. Young, Sr.		Address Same as Item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unreined</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>My hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-6 Mos years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , to <u>April 17, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George Sharpe M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) GEORGE SHARPE					22e. ADDRESS Kensington, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-21-69		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.			
24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR DATE APR 23 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) FREDERICK SION YOUNG			2a. DATE OF DEATH 4 Month 2 Day 69 Year			2b. HOUR 6:00 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT 8, 1971		6. AGE (In years lost birthday) 97 YRS.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHEVY CHASE NURSING HOME 2015 EAST WEST HIGHWAY		12a. USUAL OCCUPATION (Kind of work done most of working life, even if retired.) ARMY OFFICER		12b. KIND OF BUSINESS OR INDUSTRY ARMY OFFICER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY —		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME WILLIAM R. YOUNG		15. MOTHER'S MAIDEN NAME MARY E CAUDLE		13e. STREET AND NUMBER ARMY NAVY CLUB			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES 1948-1984		16b. SOCIAL SECURITY NO. 529-16-3160		17. INFORMANT MARY F. MATHESON - ARLINGTON, VA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) —							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 10 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec 9, 1968 , to April 2, 1969 , that (I) (we) last saw the deceased alive on April 1, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Simon C. Weiner				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 2, 1969	
22d. PHYSICIAN'S NAME (Type) SIMON C. WEINER				22e. ADDRESS 8201-16th St. Silver Spring Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/7/69		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VA.	
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, 5130 WIS. AVE. N.W., WASHINGTON, D.C.				25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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